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ABSTRACT

This publication addresses the issues of diverse health care needs and perceptions of the people of Israel based on their ethno-cultural backgrounds. Also studied is the provision of health care services and delivery systems as well as changes in the health care structure with emphasis on regionalization and community oriented primary health care. The book contains six parts (1) "Population Groups in Israel"; (2) "Perceptions of Health By Different Populations"; (3) "Epidemiological Perspectives on Health: Health Needs of Different Population Groups"; (4) "Structure and Functions of Israeli Health Services"; (5) "Problems and Fragmentation of Israel's Health System"; and (6) "Structural Redesigns to Meet the Health Needs of Israel's Populations." An extensive bibliography is included. (KWL)

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PROVIDING HEALTH CARE FOR ISRAEL'S DIVERSE ETHNIC AND RELIGIOUS POPULATIONS: NEEDS, PERCEPTIONS, SERVICES, STRUCTURES AND ADMINISTRATIVE CHANGES

HSC 575 - International Health

Teacher Preparation Program

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PROVIDING HEALTH CARE FOR ISRAEL'S DIVERSE ETHNIC AND RELIGIOUS POPULATIONS: NEEDS, PERCEPTIONS, SERVICES, STRUCTURES AND ADMINISTRATIVE CHANGES

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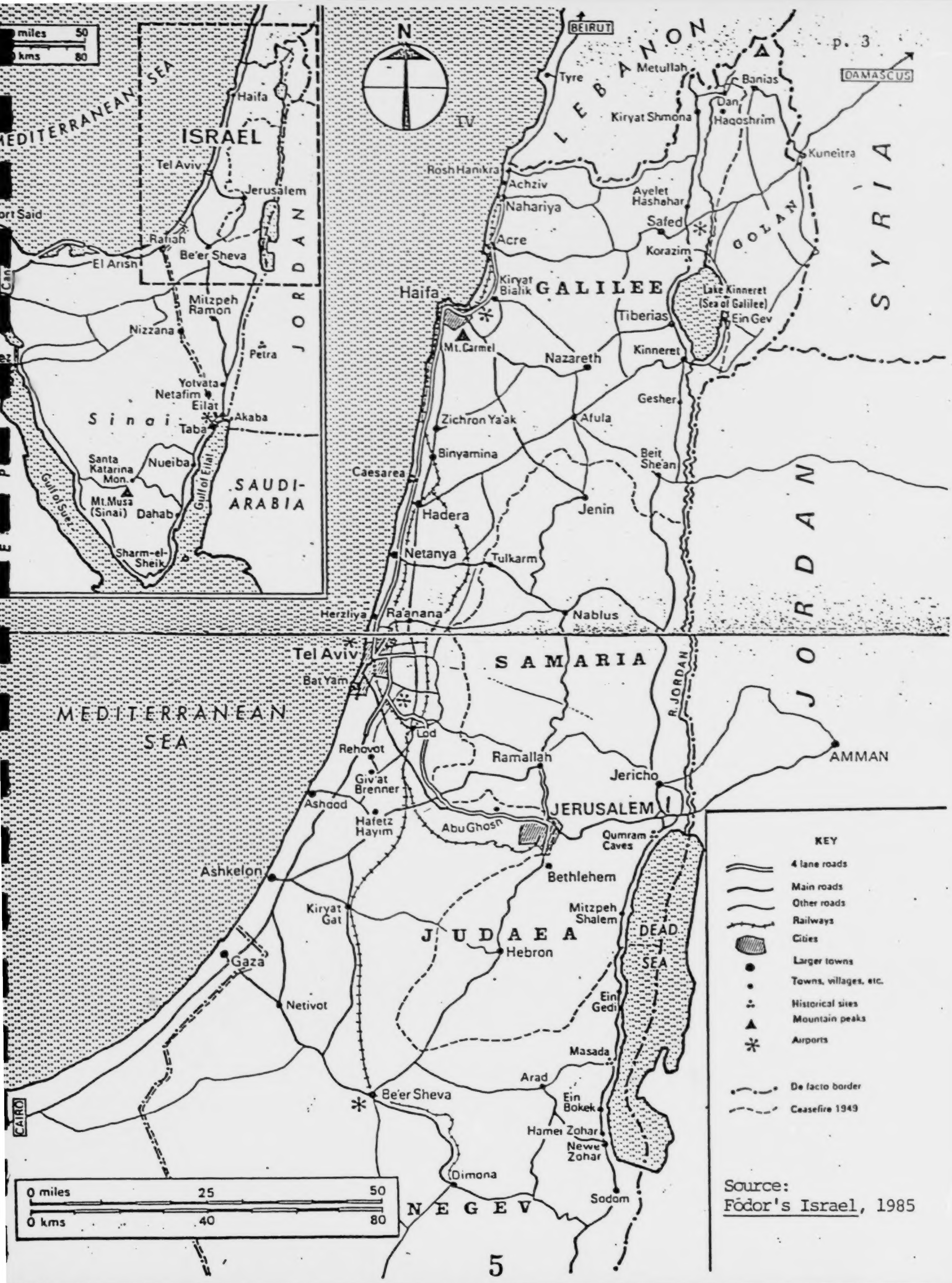
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GALILEE
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Ashkelon
Bethlehem
Kiryat Gat
Mitzpeh Shalem
JUDAEA
DEAD SEA
Gaza
Hebron
Ein Gedi
Netivot
Masada
Arad
Be'er Sheva
Ein Bokek
Hamei Zohar
Newe Zohar
CAIRO
Dimona
Sodom
NEGEV
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0 kms 40 80
KEY
4 lane roads
Main roads
Other roads
Railways
Cities
Larger towns
Towns, villages, etc.
Historical sites
Mountain peaks
Airports
De facto border
Ceasefire 1949

Source:
Fodor's Israel, 1985

INTRODUCTION

Israel is a pluralistic society with Jewish and non-Jewish population groups and sub-groups. Health perceptions and demands vary with the ethno-cultural backgrounds of these different groups, whose needs can be met more effectively through epidemiological studies and community oriented medicine. The structure of Israeli health services consists of numerous institutional participants resulting in fragmentation and overlap in health care delivery and services. To meet different populations needs, attempts are being made to redesign the health care delivery structure with an emphasis on regionalization and community oriented primary health care. The functional aspects of the current structure serve special interest groups as well as traditional political interests, and require modification to better serve the more diverse needs of all population groups.

PART I - POPULATION GROUPS IN ISRAEL

Two types of population categorizations reflect population differences in Israel, the religious categorization: Jews, Moslems, Christians, etc., and geographic or ethno-cultural categorization: Eastern Europe, Western Europe, North African, Oriental, and Levantine. Religious and ethno-cultural categorizations reflect both the unity of groups as well as the wide-ranging diversity within groups. In some cases the ethno-cultural association by people in different religious groups is close to those in other religious groups, as with Jews from Arab countries and their similarities with Arab populations. The Israeli state is organized on political dominance by the Jewish religious group, but the health care services are more broadly shaped by ethno-cultural needs interacting with structural organization.

In 1981, Israel's total population was 3,979,000 consisting of 83.5% Jews and 16.5% Non-Jews, figures defining the major dimensions of the political state. Further classification of the Jewish population on the basis of birthplace is: Israel Born (57% in 1981), Born in Asia - Africa (19.1% in 1981) and Born in Europe - America (23.9% in 1981). However, an ethnic and cultural classification is more useful for understanding the health behavior of population groups in Israel.

There are three types of Jewish populations in Israel: those affiliated with the dominant Euro-American Culture, the Ashenazim;

those Jews from Muslim countries such as Yemen, Iraq, North Africa, Ethiopia, commonly known as Edot Hamizrach (Communities of the East); and those Jews who trace their ancestry to Spain, the Sephardim. Most often, this threefold division is reduced to two: the term Sepharadim (53%) referring to those coming from the Muslim countries, and Ashkenazim (47%) referring to those Jews of Western orientation. The Jewish population includes those from the Orient, and sects such as Karaites (12,000 living near Ramla) and Samaritans (500 living near Holon or Nablus).

The Arab population in 1981 consisted of Moslems (78.1), Christians (13.9%), and Druze (8.%). The Galilee in the Northern part of Israel, has a 70% Arab population. The Arab population can be divided into Moslems - mainly of the Suni School - app. 343,900 members, (spiritual leader is the Mufti of Jerusalem); and Christians consisting of the Greek Melkite Church of app. 40,000 members (Haifa is the seat for the Archbishop); the Greek Orthodox Church of app. 260,000 member (Jerusalem is the seat for the Patriarch); the Roman Catholic Church of app. 12,000 members (Jerusalem is the seat for the Latin Patriarch); and smaller groups from the Episcopal Armenian, Coptic, Russian and Ethiopian Churches (Israel, 1984)

Changes in the composition of Non-Jewish population in Israel include a significant increase in the percentage of Moslems among the Arab population since 1950, and a corresponding decline of the Christian Arab population. Friedlander notes differences and changes, and projects figures into the future. (Friedlander, 1979, 201)

> The non-Jewish population is by no means homogeneous religiously or ethnically, nor are the demographic patterns of various subgroups within the non-Jewish population identical. Changes in the religious composition of the non-Jewish population of Israel have been slow: In 1949 the proportion of Moslems, Christians, and Druzes in Israel was 70 percent, 21 percent, and 9 percent, respectively; these have changed gradually, so that in 1970, 75 percent of the non-Jewish population were Moslems, 17 percent Christians, and 8 percent Druzes. Differential fertility accounts in large part for the trend of increase among Moslems and the decline of Christians, since mortality levels have been practically the same ... These trends are likely to continue in the future ... so that the Moslem dominance among the non-Jewish sector will increase to over 80 percent, with the proportion Christian reduced to 10 percent by the year 2010. The Moslem dominance will be particularly pronounced among the younger ages, since the Christian population experienced earlier fertility reductions. Hence, a more rapid aging process among Christians compared to Moslems may be expected in the future, other things being equal.

The Arab population in Israel is primarily a rural, non-urban group. However, urbanization of Arabs is proceeding, rapidly up from a rural figure of 3.7% in 1950, to 13.3% in 1981. Among the Arabs, the fertility per woman has been highest among the Moslem and Druze population (5.6) and lowest among the Christian population (2.4). The Moslem Arab population is increasing at a faster rate than the Christian Arabs, and is the dominant group in the Arab population in Israel.

Infant mortality for Jews per 1,000 live births dropped from 46.2 in 1950 to 12.5 in 1981. For the Arab population there was a drop from 56.0 to 23.0 during the same period. Although infant mortality for Arabs is still high, it has been dramatically reduced since 1950. Health care services, provided universaly for all populations, is credited with these changes.

Arab and Jewish populations (See Table I-1) differed significantly in live births per 1,000 in 1981 (Jews 21.4; Arabs 34.8). The total number of live births for the Non-Jewish population has increased over threefold from 7,072 in 1950 to 22,561 in 1981. For the Jewish population, the number of live births for the same period has increased from 36,359 to 70,747, not even a twofold increase. The high Arab birth rate is a matter of concern for Jewish groups wishing to maintain a clear population majority in the future State. In a study by Professors Friedlander and Goldschenider published in Population Bulletin, April, 1984, they predict that, "... if current demographic trends persist, by the year 2015, there would be near parity in the numbers of Jews and Arabs living in Israel and the occupied areas. However ... if Israel did not retain the occupied territories and returned to its pre-1967 borders, the Jewish majority in Israel would decline by only 6 percentage points by the year 2015, to about 77 percent of the population." (Israel Reports Least Immigration Since 48... 1986, 4) Meir Kahane, elected to Israel's Parliament in 1984 has provoked bitter national controversy by arguing that the only way to insure a Jewish majority is to expel all Arabs from Israel and from the territories it occupies.

There is no coordinated body of legislation on population policy in Israel but the Jewish concern for Arab population growth as well as religious considerations have led to a pronatalist climate. (Block, 1984, 830)

> A Demographic Center, established in 1968 and attached to the Prime Minister's office, had the original mandate of raising the declining natality of the Jewish population, while there was no policy to effect changes in the high fertility of the Israeli Arabs. Awareness of the problems caused by the socio-economic gap between Jews from North African or Asian countries and those of Western origin caused some questioning of the unequivocal pronatal stance. It was felt that the persistence of the fertility differential between these two groups might contribute to perpetuating the devisive social gap... In recent years there has been an increase in the use of modern contraceptives. Abortion was virtually legalized in 1977, but in 1980 was restricted for married women because of pressure from the religious parties in the government coalition.

Meir Cohen-Avidov, a right-wing Likud member of Israel's Parliament warned, "If we don't do something fast we will have parity between Jews and Arabs in 30 years, and a bi-national state." Avidov, in a proposal that "... shocked many Israelis... proposed to declare the coming year 'a year of Jewish fertility," and, during it, give substantial government subsidies to Jewish families that increased their number of children to three or more." (Israel Reports Least Immigration ... 1986, p. 4)

TABLE I-1

A. MAIN SERIES (cont.)

	1981	1970	1960	1950	יחידה Unit	
VITAL STATISTICS						**תנועה טבעית**
Jews						יהודים
Live births	70,747	61,209	44,981	36,359	no. מס'	לידות חי
Births per 1,000 population	21.4	24.2	23.9	33.0	Rate שיעור	לידות ל-1,000 תושבים
Deaths	23,268	18,425	10,404	7,148	no. מס'	פטירות
Mortality per 1,000 population	7.0	7.3	5.5	6.5	Rate שיעור	פטירות ל-1,000 תושבים
Infant mortality per 1,000 live births	12.5	18.9	27.2	46.2	"	פטירות תינוקות ל-1,000 לידות חי
Total fertility per woman	2.7	3.4	3.5	3.9	ממוצע לידות Average births	פריון כולל לאשה — סך הכל
Woman born in:						האישה ילידת:
Israel	2.8	3.1	2.8	3.9	"	ישראל
Asia-Africa	3.0	4.1	5.1	5.7	"	אסיה-אפריקה
Europe-America	2.6	2.8	2.4	3.3	"	אירופה-אמריקה
Life expectation at birth						תוחלת חיים בלידה
Males	[1]72.5	69.9	70.7	66.3	Years שנים	זכרים
Females	[1]76.2	73.3	73.5	69.5	"	נקבות
Non-Jews						לא-יהודים
Live births	22,561	16,392	11,021	7,072	no. מס'	לידות חי
Births per 1,000 population	34.8	45.7	50.3	..	Rate שיעור	לידות ל-1,000 תושבים
Deaths	2,790	1,959	1,649	1,552	no. מס'	פטירות
Mortality per 1,000 population	4.3	5.5	7.5	..	Rate שיעור	פטירות ל-1,000 תושבים
Infant mortality per 1,000 live births	23.0	37.2	48.0	56.0	"	פטירות תינוקות ל-1,000 לידות חי
Total fertility per woman	5.1	7.7	8.0	..	ממוצע לידות Average births	פריון כולל לאשה — סך הכל
Moslem	5.6	9.0	9.3	..	"	מוסלמיות
Christian	2.4	3.6	4.6	..	"	נוצריות
Druze	5.6	7.5	7.9	..	"	דרוזיות

[1] 1980

Source: Statistical Abstract of Israel, 1982, p. 7(?)

1.2 JEWISH POPULATION GROUPS: ASHKENAZIM AND SEPHARDIM

There are serious culture clashes between the Askenazim and Sephardim, the Jewish population groups. These culture clashes reflect the different national origins of the Jewish populations and cultural imperalism by Western oriented Jews seeking to retain a dominant position in Israeli political society despite the increase to majority status of the Sephardim. The Western dominance results in continued friction within Israeli society. (Editor, Spectator, 3)

> The real problem of the ethnic gap, and the resulting strife, discord and even violence between Israel's Ashkenazim and those whose antecendents were not in West and East Europe, is not a matter of designation. The root of the evil is that the antecedent of the State of Israel, that is, of the architects of the Zionist movement and of most of the pre-1948 settlers were West European and Polish and Russian Jews whose blueprint for the Jewish State was Herzl's "Old Newland" of an ideal West European society-progressive, socialist, egalitarian and comitted to Western culture.
>
> It was, and is, typical of the Western orientation of Israel that Ben-Gurion's cultural passion, besides the Hebrew Bible, was Greek literature. He studied Greek and collected books on Greek culture and literature. He was blind to the fact that Israel is in the Middle East and that geography is destiny. Ben-Gurion was (and is) typical of the tone-setting minority of Israel who are ignorant of the early high culture of the Jews of the Muslim countries described in all its many facets, major and minor, in S.D. Goitein's 5-volume, A Mediterranean Society.
>
> The Israeli curriculum of toda'ah yehudit (Jewish awareness), is heavily weighted with lessons on the shtetl, Hasidism, and the Yiddish classics, especially Sholem Aleichem. Rashi and the Gaon of Vilna receive due attention as does the "Golden Age of Hebrew Literature in Spain." But the "Jewish awareness" taught is essentially that Judaism is the creation of Ashkenazim. The pride in Jewishness aimed at and engendered by the "Jewish awareness" curriculum is pride in the pioneers of Zionism, in Hasidic stories and piety. The nostalgia for roots is for the roots of the shtetl, Rosenzweig's "Lehrhaus" and the circle of the ideologists of Zionism who wrote in German or for Jews whose Weltanschauung was formed by German "Kultur," as was also the case of Ahad Ha-Am.

The Zionist model's attempt to develop a homogeneous Jewish population has failed, thus far.

This Western Zionist view seeking to reshape Israeli Jewish populations in the Western mode comes into conflict and reinforces traditional Moslem perceptions of Israel as an extended Crusader state with roots back in the 13th century.

An expression of this perception in Syria is noted by the ABC News Chief Correspondent in Tel-Aviv,(Zelnik, 1986, 12)

> Western visitors to the Assad office describe an immense room dominated by a tapestry depiciting Saladin's victory over the Crusaders at the Horns of Hittin in 1187. The Syrian President is fond of comparing Israel's modern sojourn in the Middle East with the 132-year Crusader reign. He has referred in conversation to Jordan, Israel, and Lebanon as all part of "Greater Syria," suggesting to one startled visitor that "Jesus Christ was a Syrian Jew."

The pluralism of Israeli society and its many different populations reflects the cultural fragmentation of the Middle East region in general. Israel generates hostility because of its identification with the West, yet Zionist ideology has not succeeded in molding a single people. It is a nation still in guest of identity of regionhood, nationhood, and peoplehood. (Leibowitz, 1984, 50)

> Israel doesn't fit into the (Arab) Middle East too comfortably, and is certainly an exile in the world of nations. It is inhabited by groups of people who live on certain levels of isolation - the ultra-Orthodox Jews in their ghettos, the Arabs in their villages, the new immigrants apart from the vatikim (old-timers) in immigrant absorption centers, the religious apart from the secular, the kibbutznikim in their agricultural communities, the whole country polarized politically and ethnically and linguistically and everyone unsure about what it means to be Israeli. A friend of mine, a native-born Israeli, says he only really feels Israeli when he travels abroad. Strangers in a strange land.

The socio-economic gap between Ashkenazim and Sephardim is explained by a number of different theoretical models in Israel. The dominant model explaining this gap has been the absorption-modernization model. This model of nation building reflects all the classic notions of Zionism, pioneering, modernization, disapora negation and the essential concept of Jewish unity. It also embraces the dominance of Western culture.

Included in this model are the assumptions of the superiority of Western culture over the values and life-style of Oriental culture. The value perception of Oriental inferiority was tied to close association of the Zionist pioneers and leaders with European rather than Asiatic traditions. Golda Meir, Israel's former Prime Minister, referred to oriental Jews as the "Generation of the Desert" implying the role of Ashkenazic Jews to lead Oriental Jews out of the desert to higher civilization. Ben-Gurion, the European born Jew, classical Greek scholar, Israel's leader for independence and her first Prime Minister, expressed this view of oriental inferiority quite well. He noted in Look Magazine, Oct. 5, 1965, (Zipperstein, 1981, 26)

> (Israel's Oriental immigrants) "have come from a society that was backward, corrupt, uneducated, and lacking in independence and self-respect," (and they must be made) "to acquire the superior moral and intellectual characteristics of those who created the state."
> (Jews) from Morocco have no education. They love their wives, but they beat them... Maybe in the third generation something will appear from the Oriental Jews that is a

> little different. But I don't see it yet. The Moroccan Jew took a lot from the Moroccan Arabs. The culture of Morocco I would not like to have here. And I don't see what contribution present Persians have to make.

This Absorption-Modernization model is based on a assumptions of four causal relationships: That Sephardic inferiority has led to their low status; That Ashkenazic cultural superiority has led to their dominance in the Israeli social system; That prejudicial behavior has resulted from individual's cultural misunderstanding rather than fundamental features of the social system in Israel; and That modernizing the Sephardim will eliminate the cultural gap separating the superior Western view from the inferior Levantine view. (Zipperstein, 1981, 27)

This dominant model and variations on the assumptions of this model underly a great deal of the research and rationalizations as to why the Sephardim haven't made it in Israel. In sharp contrast to this model of inherent inferiority or superiority of Absorption-Modernization, is the Structuralist-Pluralist which explains cultural and social institutional differences between Ashkenazim and Sephardim on the basis of structural pluralism. It rejects the idea of inherent inferiority of Oriental culture and suggests that institutional differentiation between the groups is stabilized by inequality along ethnic lines supported by societal social structure and results in an Israeli caste system, the "Israeli Dilemma." (Zipperstein, 1981, 33) Adoption of that model would pose dangers of social/political upheaval similar to the Black-Panther movement which existed for a short period in Israel around 1981(?).

PART 2 - PERCEPTIONS OF HEALTH BY DIFFERENT POPULATIONS

2.1 MIDDLE EASTERN VIEWS OF HEALTH

Traditional Middle Eastern perceptions of health differ from the scientific medicine focus of modern Western systems. Both Arabs and Jews from Arab countries can be expected to exhibit some of these dominant characteristics. Shiloh notes identifying features of Middle Eastern traditional medicine. (Shiloh, 1968, 235)

> The essential philosophy underlying the system of medicine in the Middle East is that illnesses and injuries are subjective affairs arising out of personal actions conducted or not conducted, or caused by someone or something possessed with a power. Illnesses or injuries do not just occur - they befall a certain victim, at a given time, and in a definite manner because of specific causal actions.

In dealing with illness of the inner body, prevention is the major way to handle problems whereas when dealing with the external body, treatment is the primary focus. Beads, amulets and proper action are suitable preventive methods to ward off the evil spirits. Regarding pregnancy issues, (Shiloh, 1968, 237).

> From the moment of conception until the last birth pang, the pregnant woman is especially sensitive to evil spirits. Each of her actions is carefully watched by them and should she commit a transgression or omit a restriction, or not constantly invoke the power of Allah, retribution will follow as surely as might follows day. Through the actions of the pregnant woman, the evil spirits may gain access to her body to affect abortion, difficult or fatal childbirth, or imprint lasting negative results on the child.

Shiloh notes differences in defining causation between Eastern ar Western medicine, "Whereas Western medicine is very concerned with providing an accurate diagnosis of a complex of symptoms derived from the germ theory of disease, Middle Eastern medicine is essentilly concerned with ascertaining the cause of a complex of symptoms based upon the concept of the evil eye and the evil spirits." (Shiloh, 1968, 243)

However, one can live in both worlds because the two medical systems seek to prevent different phenomena, not necessarily antagonistic. (Shiloh, 1968, 243)

> Occupation with preventing the activities of the evil eye or the evil spirits is complemented by the Western preoccupation with preventing the activities of germs. A patient, or practitioner, concerned with maintaining a given state of health sees, and need see, no necessary conflict in maintaining a series of practices designed to prevent both evils.

Despite these differences between medical world views, Shiloh notes the pragmatic nature of the traditional approach to medicine. "The villager is a pragmatist, not caring who is right but ready to use the method which seems to him to work, or to try both." (Shiloh, 1968, 244) Based on this principle, there can be interaction and cross-utilization between the traditional and modern world views.

Moslem oriented population which might well rely on proper spiritual prevention, are willing to use treatment of Western medical technology where that treatment seems to work. Because there is a clearly developed theory of causation and system of prevention, based on faith and views of causation, it is probably more difficult to get the Moslem oriented population to adopt different prevention methods, especially if those methods pose a required infrastructure and system of relationships which do not fit in with the traditional patterns. Potable water and preventive sanitary conditions are intellectually less potent to ward off evil spirits than religious responses. One might postulate a possible stage theory that a persons invocation of traditional and Western medicine are selective and related to the real or perceived stages of health (prevention, care, rehabilitation), or the perceived value of suitable interventions for different health care needs.

The traditional Middle Eastern view also is hostile to a male role in women's medicine. The areas of gynecology, obstetrics, and pediatrics are under the authority of women who have acquired experience in these subjects and who are no longer menstruating. In addition to utilizing concepts and practices based on animism and animatism, these women possess a careful knowledge of local pharmacopeia and a grasp of the social and emotional factors surrounding each case. In addition, as is the case in most traditional medicine, the "local pharmacologist" also functions as a specialist in some areas. This person possesses an extensive knowledge and stock of lotions, potions, herbs, and drugs from plant, animal, and mineral sources considered to be useful in treatment. (Socio-Cultural Factors in Health Planning, N.D., 20-23)

In the traditional Middle East, youngest children are considered a blessing and especially attractive to the evil eye. To deceive the evil eye, they may be kept ragged and unkempt in public; a child's name may be kept secret so as not to be utilized for evil purposes; and a child is not to be praised in public or boasted about. Because male children are highly prized in Arab society, a male child may be dressed as a girl and referred to in the feminine until the age of five to prevent the evil eye from focusing on him. Belief in deceiving the evil eye has implications for social contacts and gaining accurate information on health. Questions as to personal or family health as well as business or status generally bring a reply of shaking heads and gloomy predictions. To accept praise or note good health, good fortune, or good looks, or God, one is careful to constantly invoke the name of Allah and/or deny the force of the evil eye. (Shiloh, 1968)

2.2 JEWISH - ISRAELI PERCEPTIONS OF HEALTH

Visits to the Doctor and Concern for Health by Jewish Israelis - A High Cultural Support and Incentive System

There is a very high usage of outpatient medical services by the Jewish population in Israel. Surveys indicate the projected visits to physicians per adult in the Jewish population was 13.5 per year in 1968, a visit to the doctor every 3.85 weeks. In the U.S. (a fee for service nation) in 1968, the average visitation rate per year for doctor was 4.2 per person (Antonovsky, 1972, 447), with visits within national health insurance schemes for the British amounting to 3.9 per year, and Yugoslavs 3.1 per year. The number of physician visits in Israel does not reflect a higher morbidity rate than that of the U.S. rather special Jewish population perceptions and interpretations of pain and poor health. " ... given an ambiguous symptom, Jews are more likely than others to see it as a sign of something serious about which something should be done, not so much in order to alleviate the symptom or pain, but in order to avoid deterioration." (Antonovsky, 1972, 449). In addition, Israel has a high number of physicians per population, 412 licensed physicians per Israel in 1970.

Jews also tend to have a perception of the future based on their cultural and historical experiences fostering a focus on health. (Antonovsky, 1972, 449)

> ... They tend to be characterized, it seems to me, by a general "rationalistic" future orientation. It is not only that one makes plans in order to reach a long-range

> goal. One weights the present in the light of its possible consequences for the future. The touchstone of a condition or activity is: what will be the takhlis (purpose)? Appropriate responses to a situation are determined not so much by the immediate meaning of the situation, but by the perceived long-range consequences. The common cold is not responded to as an experience in itself, but rather in terms of one of its supposed possible outcomes, pneumonia. Since this is the case, one had best do something about a cold, not so much to resolve the immediate discomfort, but in order to ward off something more serious.

Jews are oriented towards respect for and use of professionals to resolve ambiguity, and Jews with immigrant status are more likely to turn to and utilize health agencies for catharsis purposes. There is a supportive environment for using health resources. Generous work arrangements of no penalty sick leave time, and requirements for physician validation of illness, if one takes more than the four alloted days, have encouraged utilization of health services.

Antonovsky suggests that there is no stigma attached to visiting a doctor and the environment itself encourages turning to a doctor in ambiguous situations, and provides social and cultural for the tendency to define oneself as ill. He notes that, "A phrase that tends to enter many conversations of Israelis, particularly those that focus on dissatisfactions, is ha'ikar habriut (the important thing is health), and this phrase is extended to the frequent urging to see a doctor." (Antonovsky, 1972, 452)

He notes the cultural context and support in Israel for a health emphasis. (Antonovsky, 1972, 452)

> ... In contrast to the instrumental interpretation of health of Americans, Israeli culture (or Jewish culture) places an inherent value on health. One is bound to watch one's health because it is good to be healthy. (Obviously, the distinction is relative, not absolute.) Moreover, it is important for one to be alert to signs of illness not only in oneself, but also in those dear to one. It is this, then, that creates the environmental pressure in Israel to go to the doctor in the case of ambiguity. To do so is not only socially permitted; it is honoring one's commitment to the society, not in order to continue role performance but to remain healthy. Further, it is not only the business of family, relatives, friends and even strangers to be concerned about one's health; it can even be their moral responsibility. This tradition is clearly rooted in the ethic of mutual responsibility historically characteristic of the Jewish community, contrasting sharply to the principle of individualism inherent in the Protestant ethic.

We thus have the culture of the Jews, played out in a facilitating, fostering and supporting health services of responsive and readily available physicians, helping explain high rates of Jewish population visitations to doctors and clinics.

Immigrant groups in Israel have a greater need for catharsis. An environment providing greater access to these resources may be related to their higher physician and health service utilization. A study notes immigrant groups utilized health services and physicians for catharsis purposes more than old timers and other groups because of their more pronounced need for emotional support and sympathy to adopt the sick role. "... the length of the immigrant's stay in the host country is related to the need for catharsis and physician utilization." (Honig-Parnass, 1982, 512)

Lower classes and elderly also utilized services heavily, but in a different way. (Honig-Parnass, 1982, 512)

> ... while the lower classes and the elderly respondents did not score on the need for catharsis significantly higher than their opposite numbers, they did turn out to have other attributes found to be crucial predictors of physician utilization. Both the lower class and the elderly were found to suffer more from emotional and physical affiction, and the lower class respondents were additionally found to be more prone to adopt the sick role. ... it is the differential access to various social resources rather than any persisting communion of the former immigrant's experience which at present sets in motion the chain of variables affecting physician utilization.

2.2.1 EASTERN EUROPEAN HEALTH TRADITION OF THE JEWS

The Jewish perception of health in Israel is shaped by the dominant European cultural group. When Eastern European Jews came to Israel they brought with them a positive set of values and practices designed to help them cope with the three major components of health - prevention, treatment and rehabilitation. In addition, they collectively marshalled resources to preserve and maintain the health of their community members.

As Lindenthal notes, for Jews of that cultural heritage, (Lindenthal, 1981, 421)

> "... Nothing is worse than illness. Even the loss of parnosseh (income) is feared less than the loss of gezunt (health). Illness of one member upsets the whole household, arouses the anxiety of everyone from parents to distant relatives and neighbors. With sighs, advice and money, all participate in efforts to cure the ailment." Proper hygiene was considered essential and was accomplished through hand washing in the morning and before every meal and bathing which preceded ritual immersion.
>
> The body for the Eastern European Jew was viewed as a container for the mind, heart and soul. As a gift from the Almighty, it incurred upon its owner the obligation to preserve it intact for the time of the Messiah. Everything attached to the body was considered clean until separated from it, including hair, nails, blood or excreta.

The care and feeding of the infant for Eastern European Jews was a "model of solicitude." (Lindenthal, 1981, 42)

> Under no circumstances was the child to be exposed to any draft or to the harmful rays of sunlight. Special pains were taken to protect the child's head. Excessive yawning or crying while not considered improper was nevertheless viewed as an alarming signal. It meant that the child need to be fed and there was never any fear of overfeeding. Breast feeding was much preferred to the bottle. Weaning was related to the strength of the child. Even though swaddling was practiced the infant was never left alone. It was carried around a great deal for fear that immobility might weaken its lungs. Throughout the day, the child was constantly bombarded with words, connoting warmth and security. As the child grew older his parents discouraged outdoor games which represented a potential source of injury. Most pitied was the orphan, who did not have parents for support. Under such circumstances all outside help was to be given, but in a manner which resulted in minimal stigma to the child.

Illness, when it did arrive for the Eastern European Jew was dealt with in a number of designated ways in traditional Eastern European medicine. (Lindenthal, 1981, 422)

> When a child became ill the first line of therapy might well be an enema administered by a member of the family or by the professional "enema woman," whose primitive instrument frequently included a calf's bladder attached to a goose quill. If the mother's remedies including compresses or tea with rasberry syrup failed to ameliorate the child's condition, the services of a feltsher (male) or feltsherkeh (female) was solicited. This person might employ castor oil, gargle, cupping or in the case of severe illness, leeches. If none of these nostrums proved efficacious, the physician was called, his arrival marked by a sense of awe.
>
> He arrives by carriage or sleigh, a figure of awe, waited on hand and foot and deferred to by everyone. He sits in state while the family stand about him, the women straining and staring. His instruments, his learning, his foreign appearance and manner - he is usually a Gentile or a highly assimilated Jew - inspire wonder and uneasiness. Everyone competes to bring him whatever he asks for - a spoon, some water, a towel-and to fetch his coat when he is ready to leave.
>
> When the physician's efforts failed, the court of last resort was the Tsaddik or Rebbe, who would offer advice, prayer and possibly medication.

Eastern European Jews created the Chevre Bikur Cholim, as association whose purpose was to visit the sick and help ensure that those ailing in the community were not left alone in their suffering. (It is noteworthy that the major orthodox hospital in Jerusalem is "Bikur Cholim," named after its East European model). The East European allowed a demanding attitude on the part of the sick person and an obligation on the part of those surrounding him to meet his every need. "The preservation of health was of such paramount importance that ... literary themes involving sickness and death were employed for varying effects by both major and minor Jewish writers of the time." (Lindenthal, 1981, 423)

2.2.2. RELIGIOUS VIEWS AND HEALTH

Despite this commonality in traditional Eastern European health views, Israel is split on some health issues along religious lines. Religious values and organizations in Israel have impacted the health policy areas of abortion and autopsy, and both of these areas have been the focus of deep controversy between religious and non-religious groups. (Yishai, 1980, 434)

> The major dispute over abortion occurred between religious or nationalist and nonreligious parties. The orthodox attitude was unequivocal: abortion is permitted only in the event of clear and immediate danger to the mother's life. This attitude was grounded in a religious tenet that was not confined to observant people: "Thou shalt be fruitful and multiply and replenish the earth." These orthodox groups were supported by nationalists.
>
> The opponents of these attitudes consisted of two groups: first, "antireligious" parties that advocated the separation of state and religion. The representatives of these parties argued that abortion, despite being a social issue with economic implications, is basically a personal choice. The second group consisted of the moderate secular parties, including the dominant Labor party. These parties have regarded abortion as basically a social issue rather than a religious or psychological one. Abortion policy has been considered a mechanism for social planning; i.e., limitation of fertility among groups whose high birth-rate is not congruent with national needs.

The abortion law of 1977 as passed permitted abortion if: performed by a qualified physician in a recognized medical institution, approved by a three person committee (gynecologist, general practitioner and social worker), and based on medical, psychological or socio-economic grounds. This orthodox religious bias against abortion is reinforced by the concern that Jewish population should increase to meet a future threat of rising Arab population.

In addition to the abortion issue as a health policy concern, the autopsy issue also is significant. It has been influenced in the following manner. (Yishai, 1980, 438)

> Jewish religion opposes autopsies on various grounds, some of which are linked with belief in resurrection. The dissection of the dead without explicit consent of the family is viewed as a serious infringement of human rights. The major demand of religious groups was to hinge autopsy on explicit consent of the deceased or his family, arguing that a person's right to live according to his principles outweighs any medical advantages. Moreover, public health was undermined by the Autopsy Law, since religious people refrained from being hospitalized due to their apprehension of being dissected after death. Thus, autopsy was not only "immoral," but actually diminished the prospects of the sick to recover from their illness.

The issue was resolved by allowing families the right to prevent autopsy on religion grounds. Although both issues were important to religious groups, they were more successful in pressing the abortion issue. (Yishai, 1980, 433)

> The expansion of the abortion issue was much more successful than that of the autopsy issue. Interruption of pregnancy was linked with national priorities such as population growth and social equality. The autopsy issue has developed mainly (though not exclusively) as a controversy between zealot groups and the medical profession, each condemning its counterpart for advancing personal interests, disregarding the universal character of the problem.

2.3 ARAB VIEWS AND PERCEPTIONS ON HEALTH

Moslem Arab cultural views on the family and health, shared by many Sephardic Jews, affect health services needed and provided to different populations in Israel. With the global increase in fundamentalism among Moslem population, one can anticipate increased emphasis on finding traditional prescriptions. A traditional view is emphasized. What are the traditional health prescription of the Moslem faith?

2.3.1 ISLAMIC RELIGION AS A BASIS OF HEALTH PERCEPTIONS

The Moslem religion is a high context faith and has proscriptions regarding health practices of its religious adherents. Elazim Elbanna identified the following Islamic Health concepts as firm religious structural guides for Moslem health education. (Elbanna, 1979, 176-77)

1. Body health comes before religion;
2. Cleanliness is half of the faith;
3. All prohibitions are for the protection of the individual's and society's well-being;
4. In case of emergency (life and death), prohibitions are suspended;
5. Islam is a way of life that can develop healthy habits through practice;
6. Marriage is the only legal condition for sexual relations;
7. Abortion is considered a kind of killing a human being, but avoiding pregnancy is permissible.
8. Alcohol is prohibited. Whatever leads to similar results on human well-being is considered prohibited, whether it has been mentioned in the Qur'ān or in the Sunnah;
9. Faith is a deep belief in Allah and sincere actions;
10. Faith is to be good to oneself, family, community and society;
11. Islam has sets of norms and ethics that could be a foundation for an ideal society and a healthful environment;
12. Faith builds resistance against mental disorders;
13. To eat and drink but not be prodigal is the desired balance to reach;
14. The universe is owned by God for the benefit of the human being. Human beings have to invest this gift handed to him;
15. Every illness has a remedy. Human beings have to discover these remedies;
16. Every scientific discovery which serves and preserves the health and well-being of mankind is considered a good deed.

The above are clear fundamental imperatives for health to be followed by Moslems. The extent to which they are actually followed by Moslems in Israel is not clear from the data.

2.3.2 CONTINUITY AND DISCONTINUITY IN ARAB FAMILIES

The traditional extended family system among the Arab population, is organized on a tribal and feudal basis, the type which prevailed during the Ottoman Empire and the British Mandate. The elders were key centers of power in the community. (Rizk, 1978, 97)

> The heads of the tribes (sheikhs) enjoyed undisputed authority and power as leaders, since they were the ones who possessed the land and wealth of the community. These elders decided on matters of general policy and these decisions then became binding on all clan members. The elders also gave decisions on issues of a more personal character and on personal affairs; these decisions were accepted by every individual. The elders decided on questions regarding work or material help and other forms of assistance.
>
> This lifestyle was particularly pronounced among the rural Arab population, but was also prevalent to a considerable degree among the urban population.

Despite the traditional roots, there have been significant changes taking place in the organization and structure of Arab communities in Israel. Modernization is impacting the authority of the Sheikh, the status of women and the traditional dominance of agriculture in society. Modern Arab society is characterized by a decline of the traditional patriarchal family structure, the use of local village councils, mobility of women, greater social intercourse and a decline in agriculture as the most important occupation. Approximately 2/3 of Arabs are employed in Jewish settlements, towns and cities where they experience western lifestyles. (Rizk, 1978, 97)

In addition, "... parents no longer control their children completely, as was previously the case parental authority is dwindling and intrafamilial conflicts are more frequent. Since adaptation to and integration into the Jewish community is very difficult indeed for Arab youth, a vacuum is bound to be created." (Rizk, 1978, 97)

Yet, despite the changes, there are many significant continuities. One is that male children are of primary importance in the Arab family. (Rizk, 1978, 94)

> Even today, the prestige of each clan ("hamula") in the Arab village depends on whether or not its ranks includes a large number of young and able-bodied men. In the Arab village, a family with many children is an important asset and carries with it considerable prestige. "If they were boys they were destined to determine the social status of the hamula in earning money, aiding in all necessary work at home, sharing the fights and troubles of their clan against others. If they were girls, they also made a real contribution in running the household from early childhood on, and were supposed to enhance the prestige of the family," by not mixing with males, by guarding their virginity before marriage and by obtaining a good dowry (mohr) at the time of marriage.

Also, traditional Arab sexual attitudes differ from these characteristic of modern Israeli society. Rizk notes that in "Arab homes and schools, there is no sex education and sex is regarded as a subject to be shunned. The dogmatic attitude towards sex still exists and there is no readiness to deal with sex-related problems in this changing world." (Rizk, 1978, 102)

Sexual attitudes are affected by the lower status position of females in Arab society. (Rizk, 1978, 107)

> ... The angry cry of a young Arab unmarried girl, "We are considered bad while the boys can boast about their sex activities," simply echoes the fight against this traditional attitude. The position of women in Arab society is still in a process of transition from women as the property of men to women as independent persons with their own sense of judgement and their own integrity.

2.4 ALIENATION OF ISRAELI ARABS FROM ISRAELI SOCIETY

The modernizing changes in Arab society is taking place with increased sensitivity of Arabs to their subordinate position in the Jewish State, with a resulting feeling of alientation by some Arabs because of Jewish dominance in Israeli society. Kamil, an Israeli Arab notes that he can't serve in the Israeli armed forces because he is an Arab, and therefore loses many of the government support advantages such as housing mortgages available only to army Veterans. (Borsten, 1982, 32-33)

> He resents the practices which he considers discriminatory. For example, the Interior Ministry provides Jewish settlements with municipal grants twice and often ten times as large as those given Arab villages. Jewish settlements receive larger budgets for development, education and housing than Arab villages the same size. And no money at all is allocated to industrialize the non-Jewish sector. He is also distinctly unhappy about the fact that, though all Moslems and Christians were exempted from the military draft in the early 1960s, Israeli Arabs cannot qualify for many jobs because they don't have IDF security clearance.
>
> "So I stayed here, in this Catch-22 world where an Arab who supports the state is not believed, an Arab who criticizes the state is considered an extremist and an Arab who says nothing is suspect."

Muhammed Watad, an Arab Israeli Cabinet member, notes the changes which have taken place in the Arab population; moving from his rural village "Jatt" to an urban area. He notes too the frustration and problems of identification faced by an Arab in Israel. The interviewer notes, (Borsten, 1982, 40)

> ... , as agriculture - even on Arab farms - became mechanized and more productive, releasing more and more people into the labor market, Jatt underwent radical changes in two and a half decades. Today Watad's native town no longer contains a backward, insulated society of peasants (fellahin), for whom agriculture is a traditional and conservative way of life. It is primarily a residential area, resembling an urban community, where many residents have put their savings into modern homes, new furniture, electrical appliances and automobiles.
>
> And the people no longer grow traditional crops of olives, figs and wheat; nor do chickens and sheep still scramble in their yards. A modern economy produces profitable crops of vegetables and fruit for export abroad, using advanced agricultural machinery and expert packing and marketing methods.
>
> But the swell of progress and economic prosperity has not altered the problematic status of the Arab minority. On the contrary, the problem has worsened.
>
> "The trouble," Watad asserted, "is that there is no such thing as an Israeli nationality. There's a Jewish nationality and an Arab-Palestinian nationality, and there are those who have Israeli citizenship. I am an Israeli citizen and a Palestinian with all my heart."

Arab sensitivity to their inferior status is probably enhanced by Israeli discrimination against Arabs to limit population growth. There is de facto discrimination against increase in Arab family size but encouragement for increased Jewish family size. The Israeli Parliament "... decided to give a certain amount of money to every child, and more so to children of families where any of their relatives have been in the army. (Because only Jews and Druze could serve in the Army) that's how they overcame the problem of discriminating directly between Jewish kids and Arab kids." (Halabi, 1982, 12)

2.5 PERCEPTIONS OF HEALTH ALLOCATION IN ISRAEL

How do Israelis perceive their health services? A Dec. 1971 survey of public opinion (Public Opinion Surveys in Israel, Ltd., unpublished data) asked a representative sample of Israeli adults (excluding residents of kibbutzim): "In your opinion, does the Government spend too much, too little or just what is needed on health services?" The overall distribution of the replies was: too much, 2.1; too little, 40.0; just right, 45.4; don't know, 11.9; and no answer, 0.7%. Dissatisfied responses showed a positive correlation with the socioeconomic status of the responder, and European oriented Jews were more dissatisfied than oriental Jews. The higher the socioeconomic status of the individual, the more he is influenced by theories of absolute right to health and comprehensiveness of health services than persons in the lower socioeconomic strata, who rely mainly on their personal feelings and intuition.

Economic restraints of limited resources and competing priorities are almost unfelt in the health field in Israel and a cost-benefit approach to health problems seems almost unfeasible. This leads to a narrow outlook that disregards economic problems and other priorities and requests more funding for health. Widespread agreement exists throughout the entire political spectrum that nobody in need of health and medical services should be deprived for lack of financial means. The notion of need relies heavily on technology and standards set by a consensus of opinion among leading members of the health professions. (Halevi, 1979, 52-53)

Increased demand has resulted in increased availability of health services for the population of Israel. "The dilemma of resources has become a day-to-day issue that the leaders of the Ministry of Health have to face and struggle with. But, aside from the fact that competing needs have to be met simultaneously, we are witnessing an expansion of demands as well as an intensification of treatment processes in the various fields of care." (Haber, 1984, 456) Treatment in hemodialysis units increased from 400 in 1976 to 1,000 in 1984 (140%) to reach a very high rate of 238.1 per million population, and open heart surgery also increased from 750 in 1976 to 1400 in 1982. As Haber notes, (Haber, 1984, 456)

> The number of visits to government hospital outpatient clinics alone increase from 920,000 visits in 1976 to 1,600,000 in 1982. Referrals to emergency rooms in government hospitals increased from 698,000 in 1981 to 818,000 in 1982. These are just some examples of the trend of increasing demands on secondary and tertiary care. Our dilemma becomes more acute in direct association with improvement in diagnostic potential and therapeutic ability.

It is clear that perceptions and demands for health services differ with different population groups and have been increasing in Israel. What are the different population needs as reflected in the numerous epidemiological studies?

PART III - EPIDEMIOLOGICAL PERSPECTIVES ON HEALTH: HEALTH NEEDS OF DIFFERENT POPULATION GROUPS

The existence of different population groups in Israel has resulted in numerous epidemiological studies. Results of these studies indicate different health features of ethnic and racial, and population groups. Extensive information is available in these studies on mortality, morbidity, risk factors, and interventions. (Epstein, 1984, 243) A few have been selected here to show the value of a community medicine focus which deals with the specific health problems faced by special populations.

3.1 ARAB HEALTH NEEDS

The Arab population group, primarily rural and inhabiting smaller villages, has special problems and needs for health care services.

An American health worker who spent two years at Kfar Manda a Moslem village in the Galilee notes, (Leibowitz, 1984, 48)

> In terms of health statistics, my village in the Galilee is fairly typical of Israeli Muslim communities. This means that the infant mortality rate here is twice that of the Israeli Jewish infant mortality rate. Demographers predict that the Arab population in Israel will double within the next 20 years, as compared to 47 years for the Jewish population. For Kafr Manda and other villages like it, this population growth rate has already been translated into serious overcrowding and haphazard building. Cesspools frequently overflow and spill into the streets, including typhoid. All of which explains the importance of the public health education project for which I am working, designed to improve public sanitation and domestic hygiene.

The village of Kfar Manda is organized by clans (ham-la) with a locally elected council racked by clan feuds and spending a great deal of time discussing decades-old revenge and land disputes. She suggests that health service provisions to be effective, have to fit in with the social structure of Arab communities, and the patriarchal system. There are problems of taking health surveys in the village. (Leibowitz, 1984, 50)

> We have been working with the local village council to complete a basic health survey on environmental conditions in the village. Certain information is important to document and bring to the attention of the council: For example, in a village of 6,500 people, there are only eight trash cans. I am going over some of the results of the survey one morning, and I discover that the data just doesn't add up. In one set of questionnaires, not a single institution or home has received the lowest mark, "poor," for sanitary conditions. I ask Tawfik, the health worker who had supervised that set of questionnaires, why what should have been a standard bell curve shows only the first (steadily rising) half. He explains that he filled out that section of the survey himself, and since he knew everyone he'd interviewed, he'd felt uncomfortable about giving them poor marks.

What type of health needs can be found in the typical Arab village? The "Arab community of Israel suffers from many of the same problems that plague the Third World. Our biggest health problem in the village is infant gastroentiritis, severe diarrhea. It is the leading cause of death among children under three." (Leibowitz, 1984, 52)

> Eventually the mother took Fatmeh to the Mother and Child Health clinic in the village, staffed by four Jewish nurses from four different countries - Egypt, Algeria, Syria and Morocco. The clinic is a social center for mothers and their children, and we use this to our advantage, setting up programs in the waiting room to teach about improved sanitation and hygiene. We gave a small slide show there on the use of the refrigerator and the importance of washing vegetables and fruits, hoping to reach all the women in the village. The MCH clinic is ... a central gathering place... By the time Fatmeh's mother turned to the MCH clinic, it was too late to treat the baby at home. We had to hospitalize her. Since there is no stigma attached to sending a baby to the hospital in Nazareth, and home remedies are spurned, babies wind up in the hospital quite frequently. There is no expense involved, as membership in the socialized medical plan is automatically deducted from the father's paycheck. The mother knows the baby is getting good care in the hospital, and Fatmeh's mother has three other children at home to take care of. For a few days, there is one less child around.
>
> To be frank, I don't know how to deal with this. It seems to me that Israel's superb socialized medical system, which provides free hospitalization, is a problem in cases like Fatmeh's. It's certainly a far cry from what I'm familiar with in the United States.
>
> A main focus of our education campaign is to get women to register at the Mother and Child Health Clinic and to treat diseases early.

in 1981, had 48% of the deaths caused by congenital anomalies, 42% of deaths related to "other perinatal conditions" and lower reported population rates causing death in numerous other areas. (Chart 3.1) The real causes of however is limited by the types of reports characteristic of any official records.

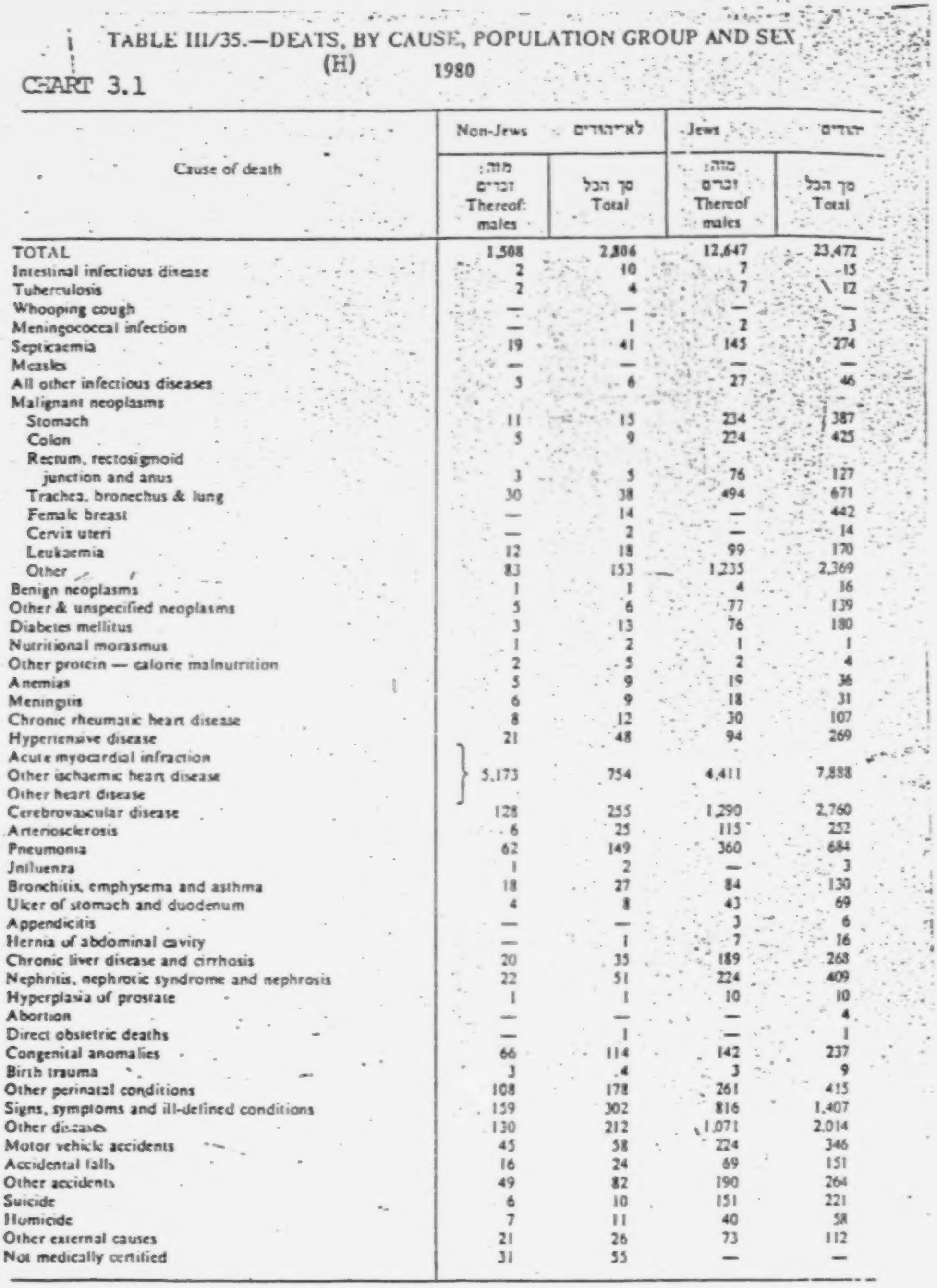

CHART 3.1

TABLE III/35.—DEATS, BY CAUSE, POPULATION GROUP AND SEX (H) 1980

Cause of death	Non-Jews לא־יהודים מזה: זכרים Thereof: males	 סך הכל Total	Jews יהודים מזה: זכרים Thereof males	 סך הכל Total
TOTAL	1,508	2,806	12,647	23,472
Intestinal infectious disease	2	10	7	15
Tuberculosis	2	4	7	12
Whooping cough	—	—	—	—
Meningococcal infection	—	1	2	3
Septicaemia	19	41	145	274
Measles	—	—	—	—
All other infectious diseases	3	6	27	46
Malignant neoplasms				
Stomach	11	15	234	387
Colon	5	9	224	425
Rectum, rectosigmoid junction and anus	3	5	76	127
Trachea, bronechus & lung	30	38	494	671
Female breast	—	14	—	442
Cervix uteri	—	2	—	14
Leukaemia	12	18	99	170
Other	83	153	1,235	2,369
Benign neoplasms	1	1	4	16
Other & unspecified neoplasms	5	6	77	139
Diabetes mellitus	3	13	76	180
Nutritional morasmus	1	2	1	1
Other protein — calorie malnutrition	2	5	2	4
Anemias	5	9	19	36
Meningitis	6	9	18	31
Chronic rheumatic heart disease	8	12	30	107
Hypertensive disease	21	48	94	269
Acute myocardial infraction Other ischaemic heart disease Other heart disease	5,173	754	4,411	7,888
Cerebrovascular disease	128	255	1,290	2,760
Arteriosclerosis	6	25	115	252
Pneumonia	62	149	360	684
Jnfluenza	1	2	—	3
Bronchitis, emphysema and asthma	18	27	84	130
Ulcer of stomach and duodenum	4	8	43	69
Appendicitis	—	—	3	6
Hernia of abdominal cavity	—	1	7	16
Chronic liver disease and cirrhosis	20	35	189	268
Nephritis, nephrotic syndrome and nephrosis	22	51	224	409
Hyperplasia of prostate	1	1	10	10
Abortion	—	—	—	4
Direct obstetric deaths	—	1	—	1
Congenital anomalies	66	114	142	237
Birth trauma	3	4	3	9
Other perinatal conditions	108	178	261	415
Signs, symptoms and ill-defined conditions	159	302	816	1,407
Other diseases	130	212	1,071	2,014
Motor vehicle accidents	45	58	224	346
Accidental falls	16	24	69	151
Other accidents	49	82	190	264
Suicide	6	10	151	221
Humicide	7	11	40	58
Other external causes	21	26	73	112
Not medically certified	31	55	—	—

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Source: Statistical Astract of Israel, 1982, p. 115

3.4 SOCIO-ECONOMIC FACTORS

The lower socio-economic condition of Jewish populations from Arabic countries and the Arab population make them more open to infectious diseases. Progress has been reported (Tulchinsky, 1983, 723)

> ... reducing mortality from infectious disease through improved socioeconomic conditions, housing, sanitation, immunization and medical treatment. Nevertheless, enteric disease is still common. Waterborne disease from inadequate water handling practices still occurs when drinking water systems lack preventive chlorination. Food-borne enteric disease is a more difficult issues for intervention; it is the result of widespread failure by the public as a whole to adopt the necessary hygienic practices. Hepatitis A is still very widespread; typhoid still occurs; salmonella, shigella and enterovirus disease are common. Diarrheal disease is still a major reason for hospitalization even though mortality rates are now very low.

Health services are universally available for all of the insured population, Arabs and Jews, and service for mothers and children are delivered both by pediatricians and family practitioners at primary care clinics. The value of primary care clinics in helping resolve the issue of pediatrician or family practitioner is a topic of debate. (Porter, 1983, 736)

> ... in Israel there is an ongoing discussion about who should provide primary health care for children - the family physician or a pediatric specialist, a primary care pediatric model, such as that established by the Health Sciences Center of the Ben-Gurion University of the Negev in Ofakim, could serve as a prototype for comparison with family practice clinics to see which is closer to the needs of children.

Although health services are universally available socio-economic features impact population mortality and morbidity. (Palley, 1983, 66)

> ...there is variability in the rates of live births, infant mortality, and life expectancy of Jews' and non-Jews. The data illustrate three developmental trends: 1) the overall improvement in health conditions, indicated by the decrease in infant mortality and the increase in life expectancy, 2) the general decrease in fertility, and 3) the persistent significant variations between the Jewish and the non-Jewish populations.
>
> The lower indicators for the non-Jewish population cannot be attributed to medical care services, since these are provided on a universal basis; they might, however, be explained by general social indicators that reveal that non-Jews are less educated, have a lower income level and live in greater population density than the Jewish population. Moreover, a survey on the use of health services conducted by the Central Bureau of Statistics indicates that the average number of visits to physicians by the non-Jewish population is 4.3 per person per year, compared with 14.0 among Jews.

The Israel health system has mother and child directed clinics which provide services for a special population. Typical are the health services available at low cost to the semi-rural Moslem Arab population at Abu Ghosh, a Moslem Arab community, 12km from Jerusalem. (Palti, Sept. 1982, 187)

> There is a mother and child health (MCH) centre in the village where preventive care is provided almost free of charge ($3 a year). The public health nurse is available every day, while the pediatrician and gynecologist work in the MCH centre once a week. Most of the population has prepaid insurance for medical care. There is in the village a clinic of the "Kupat Holim" Sick Fund of the General Federation of Labour in Israel that provides curative care.

3.3 EPIDEMIOLOGICAL DATA ON ARABS AND JEWS

Despite the universal availability of MCH clinics, there are different growth patterns in the different populations. In a comparative community child growth study, there were significant differences in weight from birth to age 2 yrs., between semi-rural Moslem children and Jerusalem raised Jewish children. The Moslem children of Abu Gosh, were found to be lighter in weight than both the Jewish children in Jerusalem, and the National Center for Health Statistics population at ages 1, 6, 12 and 24 months. (Palti, Sept. 1982, 187)

The mean weights of Abu Gosh Moslem children were compared with those of Jerusalem Jewish children from low and middle class populations. The researcher note that lighter weight of Moslem children may have been due to genetic differences as well as the higher social class and educational standards of the parents of Jerusalem children. Also, the semi-rural character of Abu Gosh compared to Urban Jerusalem, may have reflected a general pattern of taller stature children in urban populations (Palti, Sept. 1982, 190)

Within the Arab population itself there are sub-population differences related to urban/rural and social class issues. In a rural Arab area on the West Bank, male infant weight was heavier than female infant weight because of preferential treatment for males. However, in an Arab village of higher socio-economic status, near Jerusalem, this preferential pattern was not operational. Regarding (Palti, Sept. 1982, 191)

> ....growth of Arab Moslem children from birth to 3 years old in a village on the West bank of the Jordan river, (there was) a significantly higher percentage of girls ... below the 10th centile for weight and length than boys. The sex growth differential may indicate a difference in feeding practices of boys as compared with girls. Boys have higher priority than girls, as known from traditional societies. Owing to the differential behaviour in these societies malnutrition is more prevalent in girls.
> The similar pattern of growth of girls and boys in the study population suggests that no discriminative pattern in feeding practices exists by sex. It may be due to the higher socio-economic status of this population, meaning no lack of food. In addition, the population studied lives in the vicinity of Jerusalem where Western cultural and behavioural patterns predominate. Also the mother and child health services, which are regularly attended by the women during pregnancy and delivery, educate and instruct the mothers regarding child-rearing practices and survey the growth of the child closely through the first two years of life, thus affecting behaviour of the population regarding parent child interactions and promoting equalitarian behaviour toward girls and boys.

Within the Israeli Arab population and Arabs on the West Bank, efforts have been made to reduce their high level of trachoma, a major debilitating disease in the Middle East. As noted, (Bishira, 1982, 580)

> Endemic trachoma constitutes a major public health threat and is the chief cause of visual impairment and preventable blindness in certain developing countries. In fact this disease still remains a universal problem. Despite the immense efforts invested in its eradication about 400 to 500 million individuals are afficted with it.

What factors are significantly related to trachoma and what changes have been made in the environment for these factors among the child population in Arab East Jerusalem? (Bishira, 1982, 581)

> ... .the following environmental factors ...(influence) the frequency of trachoma: race, climate, insect vectors, population density, diet and nutrition, cultural and social customs, general economic level, extrinsic contacts, educational level, and the presence of other ocular or general disease.
> Among all these factors only the first 2 and the social customs have remained unchanged in East Jerusalem, while all other conditions enumerated above have been vastly improved. The marked progress in the socioeconomic conditions and educational levels have been conducive to a decrease in population density and as well as to the enhancement of the dietary and nutritional state. At the same time the tremendous decrease of insect vectors, which are mainly responsible for the extrinsic contact, has contributed to the abolition of ocular discharge transmitted by flies. The present availability of running water in almost every home and school, as well as the diminished incidence of bacterial conjunctivitis, largely facilitated the defeat of trachoma.

There has been a significant change in the prevalence of trachoma among Arab children in East Jerusalem.

As noted by (Bishra, 1982, 580)

> In an ophthalmic survey conducted in East Jerusalem during 1980 comprising 8896 nursery and primary school children aged 3 to 12 years not a single case of active trachoma could be detected. A similar study carried out in 1968, encompassing the same geographical area, revealed a prevalence of 6.4% among the school children and of 12.5% among the nursery school infants, while a subsequent survey performed in 1971, including the same population age group, showed a sharp decrease in the incidence of trachoma to a level as low as 1%. This gradual and continuous decline in the prevalence of the disease towards its end point of apparent eradication was preceded by a marked improvement in the socioeconomic status and personal and public hygiene of the general population.

3.4 DIFFERENCES BETWEEN ASHKENAZIM AND SEPHARDIM

Differences in health between Jewish population groups from Euro-America (Ashkenazim) and from the Middle East (Sephardim) are significant, and are revealed by epidemiological studies. In a sample size of 1735 Jewish and Arab newborns, comparisons were made with respect to the mother's country of origin. Babies whose mothers were of North African, Mediterranean or oriental origin were more likely to be born," at a gestational age of less than 40 weeks, & a higher percent of births took place within 1 to 2 years of a previous birth." The birth weights in different ethnic groups showed a greater range of mean birth weights in these oriental babies and a lower range in mean for those born of European mothers. (Isafrir, 1973, 71)

Breast feeding practices among European Jews differ from those of oriental Jews. (Mansbach, 1984, 160)

> Ethnicity was strongly associated with duration of breast feeding practices. Women from Western societies such as Europe and America, breast fed more and longer than those of Asian and North African origin. Women of American and European origin participate in the social movements that intend a return to natural ways of life and to lessen the influence of technology and mechanization on our daily living, whereas among Asian and North African populations, those groups that are on the threshold of modernization want to emulate that 'advanced' and 'easy' way of rearing children and get away from 'primitive' practices. This can very well be appreciated in Israel where many different cultures mingle and although services and guidance and information are basically uniform, breast feeding patterns are distinct for the different groups.

Down syndrome rates are higher for mothers of North African or Asian background than those of a European background. As noted, (Hook, 1979, 243)

> Rates of Down syndrome in livebirths in West Jerusalem in 1964-1975 were studied in relation to the mother's continent of birth or, if she was born in Israel, to the maternal grandfather's continent of birth. In women of European origin the crude livebirth rate of Down syndrome was 1.3 per 1,000 livebirths. This crude rate and the maternal age-specific rates in this group were very close to those observed in a Swedish study and two studies of white livebirths in the United States. For West Jerusalem women of North African or Asian origin the crude rate was about 2.4 per 1,000 livebirths, and at all maternal ages except the youngest their rates were higher than for women of European origin.

Hook notes the possible importance of non-genetic factors to explain the differences. (Hook, 1979, 247)

> The groups with European and non-European origin differ not only genetically but also with regard to a wide spectrum of socioeconomic, reproductive, and environmental factors. There are genetic differences between the populations of Asian and North African origin as well. Perhaps nongenetic factors - for example, lower socioeconomic status - common to both of those groups are responsible for the observed trends, although a genetic explanation cannot be excluded. Investigations in the United States of socio-economic status and rates of Down syndrome have revealed no association of any significant effect, but no such studies have been made of Jews of North African or Asian origin.

There also are ethnic differences in dental care behavior among the Jewish population within the same socio-economic class, and the purchasing of dental care between different socio-economic classes.

Within the same socio-economic class, the proportion of immigrants from Europe characterized by preventive dental behavior was more than double that of immigrants from Asia or Africa. Despite an equal level of sugar and sweets consumption among the various ethnics, different ethnic groups with equal needs differ in levels of treatment. Even in groups of respondents having the same schooling, the proportion of Afro-Asian young adults who received treatment was about half of that of all others.

To ethnic culture patterns,we must add the socio-economic variable to understand dental care behavior. (Machnes, 1980, 33-35)

> ... assuming no differences in needs, the question is how to explain the differences in the purchase of dental care between the groups. Afro-Asian households are poorer, and the head's spouse is less educated.... There is a negative influence of family size: the greater the size of the family, other basic needs such as food and clothes take precedence, and correspondingly, expenditures on dental care decrease.
>
> Most dentists live in the three big cities, so that members of households who live in other urban and rural areas must expend time and money on travel to receive dental treatment. As expected, we have noted a negative influence of physical distance from major urban cities on the level of the expenditures for dental health.

Osteoporosis is more prevalent among Jews of Far Eastern origin than among Jews of European background. (Pogrund, 1982, 134)

> The prevalence of osteoarthritis of the hip and osteoporosis of the pelvis were examined in a random population sample in Jerusalem. Of the subjects reviewed, 16.1% showed osteoporosis of the pelvis, while osteoarthritis was noted in 4.1%. In only 0.5% did osteoarthritis and osteoporosis coexist in the same individual. Osteoporosis was more prevalent in the Far East population, while osteoarthritis appeared to bear no relationship to ethnic origin. It is suggested that osteoarthritis may be associated with high levels of physical activity, a characteristic of some Eastern populations.

Hepatitus A pattern and rates among Western and oriental Jews differ on the basis of association with ethnic social class variables related to socio-economic environments. (Kark, 1981, 344)

> It is apparent that among Israelis of Eastern origin, type A hepatitis is hyperendemic, and that childhood infection is the rule. On the other hand, infection with seroconversion in those of Western origins is far less common. The ratio of the proportion of susceptibles in Western males to that in Easterners (60.3% to 15.6%, or approximately 4:1) would explain the similar ethnic ratio of clinical infectious hepatitis among the ethnic groups in the army (unpublished data).
>
> The ethnic difference in prevalence rates most probably reflects the socioeconomic differences between East and West during childhood, and the resulting hygienic and sanitary practices and standards in the ethnic groups.

Hepatitus B patterns have also been observed among five different ethnic groups of adult Israelis who immigrated to Israel about 1962. The groups from Yemen, Morocco, Iraq, India and Europe were found to have differing hepatitus B prevalence rates. The Cochin India Jews and the Ashkenazim had lower prevalence of hepatitus B regardless of age and sex whereas "The high rate of hepatitis B virus infection seen in Yemenites, Moroccans, and Kurds from Iraq reflect the known high rates of endemicity of the virus in these regions of the world." (Yodfat, 1982, 460) Yodfat concludes that, "The differences in the rates of hepatitis B virus infection among the ethnic groups studies are probably influenced by environmental factors." (Yodfat, 1982, 461)

Sephardic Jewish immigrants seem to be in a higher risk category for mental health services because of problems in adjusting to a society dominated by Western Ashkenazic values. A mental health center was established in Beit Shemesh, in the Jerusalem corridor to Tel Aviv, to cope with the problem of an industrializing area, modernization, and stresses for an ethnically heterogenous population. (Klein, 1978, 95-96)

> A considerable sector of the population of the area, namely the poor and large families of North African and western Asian origins, was especially weak and sensitive. The families displayed marked difficulties in adaptation to Israeli society and its values, which are characterized by a democratic approach, socio-economic success, competition, independence, and the idealization of concepts such as activity and labour. This cultural system is quite strange to these families, and tends to produce in them a feeling of alienation. The inability to adapt to the country was so great in some families that even the children who were born in Israel continued to consider themselves as 'new immigrants' whether through coercion, or by their own self-ideal. The clash with the new society threatened the patriarchal structure which characterizes these families. The position of the head of the family was placed in question as a result of several factors, e.g. the ever-increasing cultural and economic independence of the wife and children, lack of technical skills or sufficient emotional flexibility to adapt to the new conditions and also various physical disorders accompanying increasing age.
>
> These factors produce in the men a negative self-image and a deep feeling of not belonging in the society. They react by developing states of passivity and acute apathy, or tend to develop psychosomatic disturbances or even alcoholism, which is a common occurrence in the area (more so than in other parts of the country). In other instances they develop a tendency to extremely strong dependence on various organizations (welfare, health services) and in many cases this is accompanied by violent behaviour directed against representatives of these organizations onto whom these men project their own failures in the areas of intra-psychic and intra-familial conflicts. They not only encounter difficulties in their role as provider, but also in the paternal role as restrainer and educator. Consequently, their psycho-social

regression can be seen as an expression not only of their intra-psychic conflicts, but also of disturbances in the equilibrium of the family.

In the clinical work and the consultations with social workers and nurses, it was found that among the mothers in this population group there was a marked tendency to develop emotional disturbances, which received expression not only in overt psychopathology, e.g. persistent depressions and post-partum syndromes, but also in appearances of chronic tiredness and troublesome hypochondriacal complaints.

Genetics is an important variable which cannot be ignored when dealing with population groups of Sephardim and Askenazic groups in Israel. Goodman notes that the subgroups of Ashkenazim and Sephardim come from as many as 100 different countries. "In many instances each major community, along with its component groups, can be characterized genetically by the high frequency of certain genetic disorders found within these varying Jewish ethnic divisions." (Goodman, 1984, 461)

On the basis of demographic information, it is estimated that about 20,000 babies are born per year in Israel to couples in which both parents are of Ashkenazi origin. This means that one would expect about 6 new cases of Tye Sachs Disease per year; although only 2-3 cases per year are being diagnosed. The ultra-religious segment of the Ashkenazic community (approximately 5 percent) is not at all interested in the artificial interruption of a pregnancy because of Tye Sachs Disease and will probably not participate in screening.

The diet eaten by different population groups in Israel probably has an impact on heart disease in these groups. (Epstein, 1984, 244)

> The Israeli diet is characterized by low total fat intake, low saturated fatty acid intake, high polyunsaturated to saturated fatty acid ratio (P:S ratio), and high carbohydrate intake relative to persons in the United States and in Europe. The Israeli diet resembles diets proposed in the United States and European countries to reduce lipid levels. The diets of Israel's broad ethnic groups vary. Both the Israel Ischemic Heart Disease Study and the Lipid Research Center Study showed that adults born in North Africa tended to have higher P:S ratios than adults born in Europe. P:S ratios were similar for persons born in Israel and North Africa. The European-born group consumed more total fat, more saturated fatty acids, and fewer carbohydrates than persons born in North Africa and Israel.

For environmentally related lymphatic cancers, previous population differences between European and Oriental Jews and between Jews and Arabs in the Gaza strip has been reduced. Probably because of common exposure and a uniform health care system. (Ramot, 1984, 691-698)

> We have recently reported a change in the epidemiology of lymphatic malignancies in children of the Gaza Strip - an area where marked socioeconomic developments have occurred over a short period of time. These observations were the impetus for a countrywide survey on childhood lymphatic malignancies in order to see whether the ethnic differences previously reported, still persist after two decades of economic and social integration. It was also of interest to establish whether the 2-5 year age peak of common acute lymphoblastic leukemia (ALL) which evolved in the Western world concomitant with industrialization, and was not observed previously, has appeared ... The most interesting conclusion that can be drawn from this study is that the epidemiologic differences observed two decades ago between the various Jewish ethnic groups and Arabs have practically disappeared although the LLR in our population is still closer to developing countries than to the Western world. The disappearance of epidemiologic distinctions is most likely related to the close contact and the intermingling of the various ethnic groups, exposure to common environmental factors and a uniform child health care system for the entire population.

3.5 INFANT MORTALITY AND YOUTH SERVICES

The Jewish and Arab populations of Israel have health care needs and demands that must be met. In addition to these vertical ethnic and religious needs, there are cross ethnic age group needs in all population groups which require health care service responses. The children and elderly of Israel have needs which cut across ethnic

Care for the special population of children is a significant priority in Israeli health care. There have been prevention programs in Israel to reduce infant mortality. The infant mortality rate (IMR) has declined for the Jewish population from nearly 48/1,000 live births in the 1950s to 10.9/1,000 in 1982. (Tulchinsky, 1983) and was 11.0/1,000 in 1984 (Barrell, 1985, 3) For the non-Jewish population, the IMR fell from 70/1,000 in 1950 to 19.2/1,000 in 1982 and was 22.0/1,000 in 1985 (Barrell, 1985, 3) The national infant mortality rate in 1984 was 14.0 per 1,000 live births (Barrell, 1985, 1) This dramatic decline has been due largely to major reductions in infectious disease deaths and in birth injury-related deaths, for both Jewish and non-Jewish groups while the number of birth defect-related deaths has remained essentially stable. (Tulchinsky, 1983)

There has been a national program in Israel to reduce infant mortality differentials which range between 10/1,000 to 22 per 1,000 in different population groups. Barrell notes that, "The Israel National Program on Infant Mortality Differentials attempts to identify problem areas among the regions and communities in Israel as the first phase in a multi-staged endeavour, which includes a comprehensive analysis to identify factors influencing the high mortality rate and to characterize the population groups at risk." Information is the basic tool, and involvement of decision-makers and service managers in the process of information evaluation, and plan development and implementation is essential. (Barrell, 1985, 1)

The 1977-80 infant mortality differences between Jews and non-Jews (approximately double that of Jews) is particularly striking during the "post-neonatal period, when the average Jewish rate is 3.7 per 1000 and the average non-Jewish rate 12.7 (a relative risk of 3.4). Post-neonatal deaths are the primary component of infant mortality among non-Jews, while among Jews, the early neonatal rate represents nearly 60% of all infant deaths." (Barrell, 1985, 2)

Currently, the Israel government is studying the main causes of infant death in Israel, and the reasons for the wide population differentials (Barrell, 1985, 3)

> Inspection of the main causes of infant death in the two national groups shows significant differences in all categories except for maternal and obstetric causes and prematurity. The latter category is a combination of low birth weight related causes and respiratory distress syndrome.
>
> Congenital malformations (28%) and prematurity (27%) are the major causes of death among Jewish infants; infections (28%) and malformations (24%) are the major causes among the non-Jews. The relative risk of death from a malformation among all live births is 1.7 times greater among the non-Jews. The largest disparity among the two national populations is in infectious disease mortality (7.3/1000 among the non-Jews, 5.6 times greater than the comparable rate among Jews - 1.3 per 1000). This excess is mainly due to gastrointestinal infections.
>
> Maternal age at delivery, maternal education and parity, and differences in urban-rural residence all contribute to the differential between national groups. Multi-variate analyses are being performed for evaluation of the contribution of these factors to the differences in infant mortality.

There also has been a decline in maternal mortality in Israel (Adams, 1982, 113)

> With the development of maternity services the maternal mortality rate has decreased from 0.96/1000 live births in 1948 to 0.52/1000 live births in 1966. Grushka (1968) believed that the low maternal mortality rates were due to the introduction of maternity grants by the National Insurance Law 1953 to women who delivered in hospital. The law resulted in 100% of all deliveries taking place in hospital. To this one should add the highly developed pre-natal care ...

Maternal and Child Health Services are universally provided to all populations in Israel. These services date back to 1921 when the Hadassah medical organization opened its first community health center in the Old City of Jerusalem. Gradually, Kupat Holim(Klalit), the sick fund of the Histadrut (General Federation of Labour) and the Tel Aviv Municipality, began to open centers. Thus, in 1948, the date of independence, there was a well-established network of maternal and child health centres. The Ministry of Health undertook in the post-state period the administration of all Hadassah stations except for Kiryat Yovel, a teaching center in Jerusalem. (Adams, 1982, 112) The Jewish infant population is well served by the Maternal Health Centers. In 1982, Maternal Health Centers were attended by almost 100% of the Jewish infant population. (Dagan, 1982,) Hadassah hospital has attempted to link child rehabilitative services of East Jerusalem and its dominant Arab population, with West Jerusalem and its dominant Jewish populations. At its Center for the Prevention of Disability in the Child, Hadassah seeks to apply itself to the more complicated and sophisticated risk factors uncovered by: parental screening, maternal screening, pre-natal screening, post-natal screening, and infant and child serial developmental monitoring; Remove or neutralise these factors, if possible; Achieve the earliest possible detection of dysfunction and disability where its prevention has failed; and Initiate early interdisciplinary measures for the habilitation of each affected facet of the disabled child, and his family. (Mann, 1980, 19)

3.6 MEETING THE HEALTH NEEDS OF THE AGING POPULATION

In addition to the increased need for Youth services, the health needs of an aging population also must be met. "The aging of the population in Israel, as in most Western countries, is placing an increased demand on our health services. Hospital services, for example, are utilized by the 65+ population three times more often than by the general population." (Tulchinsky, 1983, 725) Pressures for long-term facilities has increased because of the tendency to institutionalize when community resources are not available. The proportion of 65+ population in recent years has increased by 70% compared to a 20% increase for the entire population. By 1990, the 65+ population will increase by an additional 28%, and the 75+ age group will increase by an additional 60% ("Israel Sick Fund to Expand Long-Term Care Services," 1985, 8)

Health needs, demands and services for the elderly and children have been increasing. This fits in with the traditions of Jewish culture, "Veneration of the elderly in traditional Jewish culture provides rewards near the end of life as well as it beginnings. It provides for continuity of psychological life and self-esteem until the end of natural life. (Stambler, 1980, 337)

The elderly in Israel represent a significant population group requiring and utilizing health care services. Their health needs can't be met by traditional medical care services but relate to cultural patterns, and standards of living of different populations. "The design of health care services in Israel must be based on an integrated network of health, community and social support systems derived from an understanding of the patient in his family and community, and as a separate and distinct socio-cultural population." (Davies, 1981, 143)

The dilemma of resource allocation was expressed by prioritizing in the late 1970's, at which time there was a basic policy shift in public health in Israel to health education issues. [illegible] most regions of the state the problems in public health have shifted from the priorities of lowering mortality rates to health education, solving the social problems of all age groups beginning with the need for "head start" programmes for the very young, to dealing with problems of the adolescent and ending with the needs of the aged." (Adams, 1980, 113)

There has been an impact of the aging population on urban health facilities. The aging population has special health care needs and perceives and utilizes services in a different manner. The aged have remained in the major cities of Israel and require special services. The Tel Aviv Medical Center serves an area with 270,000 residents, more than 20 percent of whom are over 65 years of age. This high proportion of elderly patients and increasing costs of hospitalization have prompted the center to develop alternative health care services that have made it possible for a number of age patients to remain at home and ambulatory. Two alternatives to hospitalization provided are the Center's Day Care Clinic and Home Care Clinic. (Michaeli, 1984, p. 448) The expansion of elderly population has resulted in changes in the distribution of hospital beds at this center. There has been a decline in number of beds in

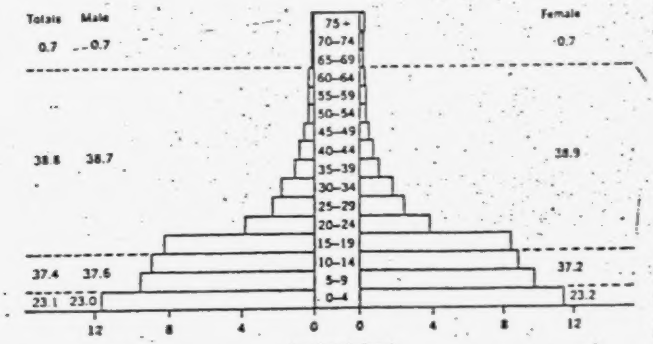
Pediatrics from 84(1978) to 48(1982) and in obstetrics from 100(1978) to 80(1982.) Concurrently, there has been an increase in beds for such specialties as geriatrics (from 20 to 48 between 1978-82), urology (from 30 to 35 between 1978-82), and cardiac surgery (none in 1978 to 21 in 1982).(Michaeli, 1984, 448)

The Kupat Holim of the Histadrut, at its last annual conference, adopted a major four-year program to expand long-term care services for the elderly. As noted, Israel Sick Fund to Expand Long-Term Services, 1985, 8)

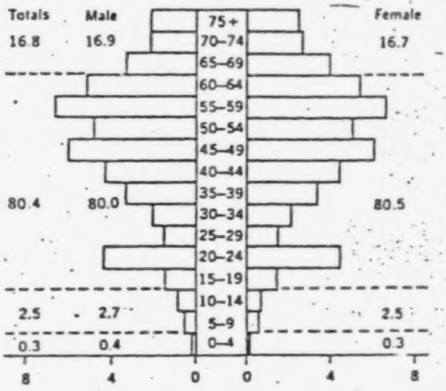
> Services in preventive medicine, treatment and rehabilitation will all be expanded. The number of units providing home care will be doubled, ten centers providing day care and rehabilitation will be added, as well as 1,000 beds for long-term hospitalization. Geriatric and rehabilitation departments will be developed in general hospitals and services expanded in homes for the aged.

The following chart on Age-Sex Distributions of Jewish Population Sub-Groups in Israel (Friedlander, 1979, 200) notes the demographic changes in population age cohorts. It also suggests some of the inherent political problems in developing priorities for special services. The aging population are primarily European born Jews whereas the younger population are primarily Jews born in Asia and Africa and Arabs (not shown on bar graph). Policy decisions on allocating resources to elderly or youth affect the different ethnic and religious populations in Israel, and are of political consequence.

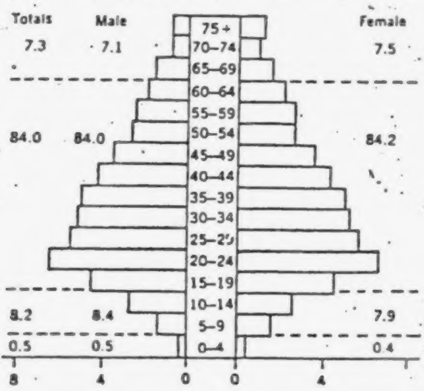
8.2 Age-Sex Distributions of Population Subgroups in Israel



Jews born in Israel



Jews born in Europe and America



Jews born in Asia and Africa

(Friedlander, 1979, 200)

PART IV - STRUCTURE AND FUNCTION OF ISRAELI HEALTH SERVICES

4.1 PLAYERS IN THE HEALTH GAME

The institutional players in the Israeli health care field are the government with its Ministry of Health and Ministry of Social Welfare, the Kupot Holim Sickness Insurance funds, of which the Kupat Holim Klalit (the General Confederation of Labor-Histadrut-Sickness Insurance Fund) is by for the largest, the Hadassah organization and other external organizations largely supported by Jewish groups in the U.S. and overseas.

4.1.1 KUPAT HOLIM

Kupat Holim is the sick fund of the Histadrut General Confederation of Labor and is the major non-governmental health insurance organization in Israel. Its historical roots date back to 1912 when the Sick Fund of Jewish Agricultural Labor and socialist groups in Judea and Galilee was established. When the Histadrut General Confederation of Labor was founded in 1920, the Kupat Holim became part of that labor organization.

As part of the Ottoman Turkish Empire until 1917, Palestine was characterized by a lack of health and sanitary facilities, and diseases such as malaria, trachoma, parasitoses and diarrheal diseases. Health services were very limited, and this European style sick fund and mutual aid society was a major health advance. (Tulchinsky, 1985, 245)

The Histadrut General Confederation of Labor is today the largest voluntary organization in Israel, and the most important economic body in the state. It is open to all workers, including members of co-operatives and of the liberal professions, who join directly as individuals. The Histradrut engages in four main fields of activity: trade union organization; economic development; social insurance based on mutual aid; and educational and cultural activities. It is not only a labor movement but a socio-political organization allied to the Labor Party and an economic enterprise which accounts for 20% of Israels G.N.P. (Palley, 1983, 68) Linkage among the Histadrut, the Labor Party and Kupat Holim are strong and the Kupat Holim is a well protected political entity of the Histadrut. Dues of 4.5% of wages,cover all its trade union, health and social services activities.

In 1983 the Histadrut had a membership of 1,600,000, including over 160,000 in collective, co-operative and private villages affiliated through the Agricultural Workers' Union, and 360,000 wives (who have membership status); 170,000 of the members were Arabs. In addition 110,000 young people under 18 years of age belong to the Organization of Working and Student Youth, a direct affiliate of the Histadrut. The main religious labour organizations, Histadrut Hapoel Hamizrachi and Histadrut Poalei Agudat Israel, belong to the trade union section and welfare services, of Kupat Holim(Klalit),which extends to 85% of all workers in Israel. ("Israel," The Europa Yearbook, 1984, 1772)

Reflecting its quasi-governmental role, the Executive Committee of the Histadrut consists of the departments of: Trade Union, Integration of Arab Members, Mutual Security Centre, Organization, International, Finance, Legal, Employment, Vocational Training, Absorption and Development, Academic Workers, Culture and Education, Institute of Economic and Social Research, Diaspora Communities, Youth and Sport, Consumers' Authority, Industrial Democracy, Religious Affairs and Higher Education. ("Israel," The Europa Yearbook, 1984, 1772). The departments are the types one finds on a governmental cabinet level.

Kupat Holim has frequently clashed with the Ministry of Health, even under the Labor government, over its power and prerogatives. (Palley, 1983, 68)

Kupat Holim also provides services for the 15% of workers who are not members,through government insurance payments and subsidies (Bituach Leumi) for 84,000 elderly poor in 1978, and for hospital construction (Israel's treasury subsidizes 30-50% of their capital development budget and services). With its network of 16 hospitals, 1/3 of the nations hospital beds, 5554 medical workers and staff,4 long-term rehabilitation and chronic disease hospitals, 2 psychiatric institutions, and over 1,181 medical clinics, dental clinics and convalescent homes, Kupat Holim is the major power in Israeli health care.

Kupat Holim secures its funds in 4 ways

1) Membership dues, which are part of Histadrut fees which all Histadrut members pay;
2) Employer funds equivalent to 3.7% of the workers salary;
3) Financing by the government. (Hospital subsidies pay for providing childbirth & hospital maternity care)
4) Through membership of religious parties who are affiliated through their organizations and not as individuals

Kupat Holim retains the socialist ideals of mutual aid but has repeatedly rejected attempt to establish National Health Insurance because it would relegate Kupat Holim to a service provider role and undercut its political powers.

Other sick funds do not maintain hospitals but provide full services by direct purchase mainly from Kupat Holim. These sick funds are:

-National Sick Fund-established in 1933 by Herut the right wing group. In 1964, Herut joined the Histadrut health plan.

-United Sick Fund-established in 1930 by the General Zionists. Its membership is now 8% of the insured and it attracts a middle class and self-employed constituency, and

-Maccabi-Assaf-established in 1941 by unemployed physicians. It appeals to professionals and urban affluents and has enrolled 12% of the insured population.

Haim Doron, Chairman of the Executive Committee of Kupat Holim, notes the vital role of Kupat Holim in all stages of care (Doron, 1984, 450)

> The concept of primary care in the Kupat Holim Health Insurance Institution encompasses all the stages of health: the promotion of health, personal preventive care, curative care, and rehabilitation in the community. Primary care is, thus, the foundation of this nationwide comprehensive health insurance and health care delivery system.

He notes Kupat Holim involvement in the planning process in what is evidently a traditional grant planning role. (Doron, 1984, 451)

> The planning process is vital to achieve the basic objectives of delivering comprehensive, high-quality care with equal availability and accessibility for the entire population served. Today, persons involved in health policy question the necessity for round-the-clock availability and unlimited accessibility. Equity, however, cannot be compromised, and care must be given within the economic constraints of the system.

Doron notes the innovative role of Kupat Holim for Health Care services in Israel. (Doron, 1983, 694)

> New concepts and patterns of care developed and implemented by Kupat Holim over recent years include an extended team with new kinds of primary care providers, health education activities, prevention, increased home care, and changes in the schedules and in the planning of clinics. These changes have required new concepts of training and education with close cooperation between services and academic institutions.

4.1.2 MINISTRY OF HEALTH

Ministry of Health operations include traditional ministerial functions of planning, supervising and coordinating services, as well as provision of direct services through different health care operations. About one-half of the beds in general hospitals, most of the nations family health centers and over two-thirds of the beds in long-term hospitals are run by the Ministry of Health. (Ellencweig, 1983, 361)

A conflict of interest faced by the Ministry of Health involves its multiple judicial, administrative and service roles. It handles traditional ministerial functions e.g., planning, supervision and coordination of services, as well as the operational aspects of health. The Director of Hospitals manages about one-half of the state hospitals, and has legal authority over the entire hospital system. Through the Director, the Ministry both sets policy and administers as well as provides direct services in hospitals, health stations and community programs.

Both the Ministry of Health and Kupat Holim have internal conflicts between roles as political decision-makers and roles to meet health care needs. Dual roles of improving health care and strengthening one's political constitutency are inherently in conflict. The Ministry of Health functions within a coalition government framework and faces problems of decision-making and administration. These decisions must keep in mind the need to politically satisfy member parties of the coalition government, possibly at the cost of unsound health care. Kupat Holim also has the general political interests of advancing the Labor Party base which may well be in conflict with advancing the National health interests advocated by the Ministry of Health.

4.1.3 HADASSAH AND OTHER EXTERNAL AGENCIES AS REPRESENTATIVES OF WESTERN HIGH-TECH MEDICINE

In addition to Kupat Holim and the Ministry of Health, a number of external agencies supported by Jews outside of Israel are players on the health scene. These organizations reflect the commitments and ideologies of their external constituencies rather than the priority and national needs of Israel health. As such, they contribute to the already existing fragmentation of the health care system. Hadassah is the most significant of this group, which includes Magen David Adom (Red Star of David) and diaspora religious agencies.

Hadassah is an American Jewish womens organization which along with its other activities, supports health services in Israel. It maintains the Hadassah University Hospital and its medical school for teaching, and contributes to the support of Hebrew University. The significance of Hadassah is its representation and advocacy of Western high-tech medicine in contrast to public health and community medicine inherent in the Labor Party dominated position of Kupat Holim. Until recently, Hadassah with its American extrepreneurial model, set the tone for medical training in Israel. Social medicine and family practice are secondary to clinical and laboratory research, and public health fares poorly when competing with commitments to advanced technology.

The Hadassah Medical School of the Hebrew University serves as a conduit for American contributions toward specific programs, and has set a tone in directing energies towards the high tech model of medicine. With American money, consultation and professional advice "Hadassah's approach imposed an American medical educational system and philosophy upon the Israel scene along with its contributions." (Silver, ,51)

The availability of Hadassah funds for American oriented special projects was the mold shaping Israeli medicine. The "Hadassah largesse was irresistible and for the government or medical planners to insist on constraints, against the advice of their own professionals, in view of the growing state's tremendous needs was politically unthinkable." (Silver, , 52)

Consistent with the American model of doctor training, only 7 per cent of Israeli doctors in 1973 went into primary care, although 50% of Israeli physicians were in primary care. This discrepancy was made up by immigrant physicians. (Silver, , 52)

Hadassah helped shape the pre- and post-state medical organization according to American perceptions and criteria by stressing the professional education approach characteristic of the Harvard Medical School rather than the training of family doctors stressed by Kupat Holim. This "... inflated the cost of medical care, widened the gap between rich and poor, black and white, urban and rural dwellers. It has inflated physician incomes to an incredible degree, glorified technology at the expense of human needs and both these factors have locked medicine away from the necessary, humble pursuit of social responsibility." (Silver, , 55)

The appropriateness of this model to Israel is questionable because of the more egalitarian structure and social orientation of Kibbutz and Moshav society. This model has been in stark contrast with health care as practiced in the broader Middle Eastern area, and has reinforced the Arab view of Israel as an alien state.

According to Silver, the real medical needs of Israel were quite different from the perception of these needs by Hadassah (Silver, 55)

> Israel needed doctors and health workers trained and educated in the aspirations of a democratic socialist state in the Middle East. It needed family doctors, few specialists, many paraprofessionals, strong health educational services to cope with the special needs of living in such a climate, under such industrial conditions, agricultural conditions, disease prevalence. Instead it got a formula... for medical care delivery that had no relevance to the situation and carried with it the seeds of diastrous consequences. Specialists mean not only fewer family doctors, but more expensive facilities, more expensive doctors and an ascending spiral of inattention to basic problems of medical practice and increasing cost. Kupat Holim, for all its own rigidities, recognized this and pleaded with the Medical School and Hadassah for corrective action. On more than one occasion I was witness to debates and bitter arguments between Kupat Holim officials. But here other types of arrogance supervened: professional contempt from the specialists in the medical school: hostility from middle class community leaders in America to the trade unionism of Kupat Holim.

Hadassah's focus set the frame for some of the types of problems Israel currently faces with its health services operations. "The Hadassah medical machine is an enclave in Israel society built with American money, and now dependent on Israeli money to pay for an elite expensive research tool." (Silver, , 55).
has expanded and dominates in a health setting where people want technology facilities available in all hospitals.

In recent years, there has been movement away from the training emphasis of high-tech medicine to a greater emphasis on community medicine. In the early 1970's there were four medical schools, but only one academic program in Public Health at Hadassah Medical School in Jerusalem. In 1977, 283 students received degrees in general medicine or dental medicine, but only eight were graduated in Public Health. By 1982, changes took place with the establishment of a community-based approach, and new academic training programs in Public Health at Bar Ilan and Haifa Universities. In addition Beer-Sheva University stressed integration of different health disciplines through a comprehensive community approach. The Health Sciences Center at Ben Gurion University of the Negev in Ofakim, has developed an ambulatory pediatric teaching clinic and has established a comprehensive community oriented pediatric care program (Ellenzweig, 1982, 256) However, the problem of high-tech medicine remains.

Haim Doron, Head of Kupat Holim comments on this problem of high-tech medicine. He doesn't mention Hadassah directly but presents the classical problem faced by nations with limited health resources; How much for high-tech entrepreneurial medicine and how much for community medicine for all the populations. From his perspective Israel has a problem of proliferation related to high-tech medicine.(Doron, 1982, 361)

> In Israel more - and possibly undue - emphasis has been placed on division by specialty rather than by functional unit, and to some extent at the expense of the patient's well-being...
>
> Although Israel is a small country, we have many medical professionals of high quality. There is a constant effort to keep abreast of medical developments and to acquire the tools to make use of the skills developed both here and abroad. Initially, these efforts led to the establishment of many units for intensive coronary care, dialysis and intensive respiratory care. Such units have now become an integral part of most general hospitals regardless of their size and location. While it may not be fair to say that these units are superfluous, the effectiveness of care provided by such units in the early years may have been low. Now we have the same trend with a new range of special units, including those for intensive neonatal care, burns, oncology and open heart surgery. Advances in technology have added costly and sophisticated medical equipment, such as computerized axial tomography scanners, to this list. Nations that have adopted health care resources planning laws, or even principles, have stipulated that such units need not be part and parcel of every creditable hospital. Not only for the sake of economy, but also to ensure the necessary competence that can only be gained by continuous experience, installation of these facilities should be limited to regional hospital centers. In Israel their development has been sporadic and has had no geographic regional basis. The predominant reasons are the absence of governmental controls on capital expenditures, and the very natural desire of the various health care systems and even of individual hospitals to develop the best in modern medical care. In the last several years, even the interagency Hospital Planning Authority ceased to function.

Israels high level medical technology is reflected by the development and production of CAT scanners and magnetic image resonators by the Elcint corporation. The major high-tech developments in the Israeli system reinforce the danger of health care becoming less equal as it becomes more technologically sophisticated and more specialized. Such knowledge is limited to less groups in select areas of the country, so that the equality that once existed can be endangered by the advance of high-tech medicine. (Summary of Workshop Discussions, 1982, p. 422)

4.2 THE POLITICAL PROCESS OF MULTI-PLAYERS IN HEALTH

There are a multiplicity of players on the health care scene resulting in conflicts regarding issues of broader services to the community vs. high technology medicine. On what basis and through what process is the structure shaped for resulting decisions? (Yishai, 1982, 290)

> It is common knowledge that medical agenda is not merely or even mainly determined by health needs. Rather it manifests a host of political, economic and personal interests which seek to be advanced through the medical issue. Put differently the medical issue is in some cases no more than an instrument for the articulation of other pressing needs.
>
> Health problems are deeply interwoven into the social and political fabrics. Their multidimensional facet also determine the manner in which medical resources are allocated. The struggle over an issue, which ostensibly is grounded in health rationale, may be imbued with competition on power and resources.
>
> Lastly, it seems that there is no one road to the heaven of an optimal provision of health services. Rather, there is a variety of medical options tainted by political colours. Health issues are subject to bargaining and power struggles in an open political market in which each of the contenders trades his resources for desired objectives. As noted elsewhere, consensus barely exists except on the most abstract 'welfare of the patient' level. Who is to determine the contents of this 'welfare' and the means for its attainment?
>
> The futile introduction of the NHI (National Health Insurance) in Israel... demonstrates that in a society in which politics ranks as prime, health services cannot be isolated from the mainstream. In fact, the case presents one of the most politicized health service systems among the democratic nations.

The structure of the health care system in Israel poses problems for those wishing a more community oriented populations focused medicine. The following chart provides a summary of the basic structure and functions of the formal system:

4.3 SUMMARY FUNCTIONS OF FIVE PLAYERS ON THE ISRAELI HEALTH CARE SCENE

1. MINISTRY OF HEALTH

1.1 MEDICAL DIVISION (PUBLIC HEALTH, MENTAL HEALTH & HOSPITAL SERVICES)
1.2 PLANNING DIVISION
1.3 MANPOWER & ADMINISTRATION DIVISION

A. AUTHORITY & RESPONSIBILITY

Overall authority for planning and supervising health care services, licensing and setting standards for the health professions, supervising sanitation authorities (i.e., local authorities), as well as providing certain preventive, curative and rehabilitative services. Provides certificate of need for new or altered health services.

B. TRENDS

In the past, the Ministry took responsibility for many services initiated by voluntary agencies, especially in the fields of geriatrics, psychiatry and child care. Present trends are toward the transfer of direct services from the Ministry to other caregiving agencies, such as the kupot holim, with the Ministry focusing on setting standards and supervising the health services.

C. PROVISION OF DIRECT SERVICES

The Ministry directly operates 34 hospitals that provide about 38% of all hospital beds, some 69% of the family health stations, most psychiatric facilities and many geriatric services, as well as a number of nursing schools, public health laboratories, child development centers, mental health clinics, and hospitals, rehabilitation centers and two physiotherapy schools.

D. OTHER SERVICES

Preventive, Hospitals, Maternal & Child/Care, Psychiatric, Geriatric

2. KUPOT HOLIM

(VOLUNTARY SICK FUNDS)

Kupat Holim - Histadrut Sick Fund
Kupot Holim - Other sick funds

A. TYPES

There are 4 major sick funds:

1. Kupat Holim Klalit (the Worker's Sick Fund of the General Federation of Labor, the Histadrut). This is the largest sick fund, covering nearly 2.9 million people, or about 80% of the insured population. It employs some 50% of the doctors over 1.200 ambulatory care clinics (including over 200 maternal and child health clinics), 14 hospitals and many laboratory, convalescent and other facilities.
2. Kupot Holim (Other sick funds) The other three smaller sick funds (Kupot Holim Leumit, Meuhedet and Maccabi) provide health insurance and services to some 17% of the total population and 19% of the insured population.

B. SERVICES OF ALL THE SICK FUNDS

Cover over 92% of the population for prepaid medical, hospital, drug, convalescent and other services.

C. OTHER SERVICES

1. Preventive
2. Hospitals
3. Maternal & Child Health
4. Psychiatric

3. MUNICIPALITIES

SERVICES

1. Preventive (Jerusalem & Tel-Aviv)
2. Welfare
3. Maternal & Child Care (Tel-Aviv & Jerusalem)
4. Social Services (Ministry funding)

4. MINISTRY OF SOCIAL WELFARE

SERVICES

1. Welfare

5. VOLUNTARY AGENCIES

SERVICES

1. Ambulance (Magen David Adom)
2. Hospitals
3. Psychiatric
4. Geriatric
5. Ambulatory Care

Data for chart from Tulchinsky, "Israel Health..." 1982, and other sources

PART 5 - PROBLEMS AND FRAGMENTATION OF ISRAEL'S HEALTH SERVICES

5.1 FRAGMENTATION

The fragmented and overlapping structure and organization of health care services in Israel poses difficulties for servicing the health care needs of the many populations. Attempts to reform the structure are discussed in the next part.

The "System lacks planning and coordination, causes discontent among the population, and results in a cost of services that is unjustifiably high." (Ellencweig, 1983, 367) Various organizations in Israel provide overlapping health services of curative, preventive and welfare dimensions under auspices of separate agencies. "Even in small towns, health and social services are provided by many agencies. Each health care agency is responsible for its own service and there is a lack of joint functioning on the administrative and service levels." (Palti, 1981, 112) Major coordinated planning is difficult.

There is extensive duplication of services among service providers from both the Ministry of Health and Kupat Holim which run parallel to each other and frequently overlap. In addition the Ministry of Health has been overshadowed for many years by Kupat Holim with non-governmental hospitals rated higher than governmental hospitals in regard to maintenance, equipment and personnel development. Members of the Kupat Holim generally see their role & function as more important than that of the Ministry of Health. The high self-esteem of Kupat Holim is based on its major provision of care, large population coverage (over 80%), its position as the founding and decisive element in Israeli public health, its ideological labor principle of mutual aid, and its position as an independent medical organization and component of the powerful Histadrut Labor union. (Ellencweig, 1983, 371)

The following chart of Hospital Bed Ownership illustrates the beds provided in Israeli hospitals, and the different organizations providing these beds.

5.2 SERVICES AND PROVIDERS

HOSPITAL BED OWNERSHIP*

	OWNERSHIP	GENERAL BEDS	LONG-TERM GERIATRIC & PSYCHIATRIC BEDS
1.	Government	36.8%	39.4%
2.	Sickness Fund (General Sickness Fund is the only one that owns hospitals)	30.7%	8.8%
3.	Municipal & Government	11. %	2.0%
4.	Public (Non-Profit)	18.3%	10.7%
5.	Private	3.2%	39.1%

* Information based on (Ellencweig, 1983, 368)

Overlap and fragmentation is reflected by the number of organizations delivering the same types of services in Israel. Health related services in Israel and the agencies delivering these services are the following: *

SERVICES	PRIMARY PROVIDER ORGANIZATIONS
A. Preventive Services	-Mainly by the public Health Services of the Ministry of Health. Also by the municipalities of Jerusalem and Tel Aviv and the Kupat Holim Sick Fund.
B. Sickness insurance held by most of the population (In 1984, 96% of the Israeli population was insured by one of the four sick funds)	Kupat Holim covers 83% of those insured by sick funds.
C. Welfare Services	Operated mainly by local authorities with funding and supervision from the Ministry of Labor and Social Welfare.

* (Information from Palti, 1981, 1124; Tulchinsky, 1982, 345, and Ellencweig, 1982, 251)

SERVICES	PRIMARY PROVIDER AGENCIES
D. Ambulance Services	Organized by local branches of Magen David Adam, a voluntary organization
E. Ambulatory patients	Mainly independent sick funds
F. Hospitals	-Government -Kupat Holim -Voluntary agencies & sick funds
G. Maternal & Child Health	-National Gov't. Public Health Service -Some municipalities (Tel Aviv, Jerusalem) -Kupat Holim
H. Psychiatric Services	-Ministry of Health -Kupat Holim -Voluntary agencies
I. Geriatric Services	-Mainly administered by the government -A large number of private and voluntary care facilities
J. Social Services	-Municipalities with funding and supervision supplied by Ministry of Labor and Social Welfare
K. Ambulatory Care Services	Primarily through independent sick funds.

Pluralistic societies such as the United States and Israel(unlike homogeneous societies like Poland)have policy-making processes which include the interest groups in society. (Stambler, 1984) This is a source of strength in terms of innovation and creative resolution of conflict but an obstacle in terms of developing a rational comprehensive and universal system of health care. (Lee, 1982, 385) Israel is innovative and creative but has a fragmented operation. Its health care services are divided among a number of different groups. (Lazin, 1983, 463)

> In Israel, medical care is provided in a highly institutionalized, fragmented system with little coordination. The Ministry of Health is responsible for preventive medicine and provides for public and mental health services. On the neighborhood level, it operates free mother-child centers where nurses give preventive care to newborn babies and expectant mothers. Curative health services, in contrast, are the responsibility of non-profit public sickness fund of the General Labor Federation, (It) provides care through neighborhood clinics staffed by doctors and nurses and supported by regional outpatient clinics and hospitals. The Ministry of Labor and Social Betterment ... administers welfare services on the community level through municipal agencies. In general, there is no coordination on the neighborhood level between the Ministry of Health and the sickness funds on the one hand, and health and social welfare sectors on the other.

How is this overlap reflected on the local level?

In 1981, there was a multiplicity and overlap of health services on a local level. Palti wrote on a case study of Bet Shemesh, a community of 11,500 people located between Tel-Aviv and Jerusalem, (Palti, 1981, 112)

> Health services in Israel are provided by various organizations. In most areas, curative, preventive and welfare services are under the administration of separate agencies. Even in small towns, health and social services are provided by many agencies. Each health care agency is responsible for its own service and there is a lack of joint functioning on the administrative and service levels. To illustrate this, a locality of 11,500 people is described in relation to the characteristics of the population, health care services and other agencies, manpower and use of services.

The lack of coordination and duplication of health care services in the Bet Shemesh community are reflected in the following illustration:

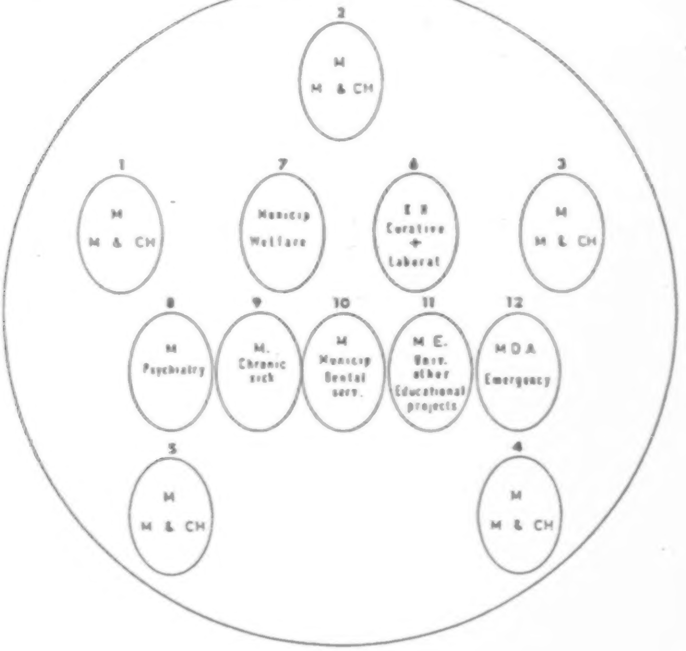

2
M
M & CH
1
M
M & CH
7
Municip
Welfare
6
KH
Curative
+
Laborat
3
M
M & CH
8
M
Psychiatry
9
M.
Chronic
sick
10
M
Municip
Dental
serv.
11
M E.
Univ.
other
Educational
projects
12
MDA
Emergency
5
M
M & CH
4
M
M & CH

Fig. 2. Existing local services.

Services: 1–5, Preventive services in family health centers, predominantly maternal and child health (M & CH); 6, Curative services and laboratory; 7, Welfare services; 8, Psychiatry; 9, Service for the chronic sick; 10, Dental service; 11, Educational projects; 12, Emergency service. **Agencies:** M: Ministry of Health; KH: Kupat Holim; Municip: Municipality; ME: Ministry of Education; Univ: Dept. of Education, Hebrew University; Other: Kibbutzim, Beit Shemesh community center; MDA: Magen David Adom.

(Palti, 1981, 114)

5.3 REASONS FOR FRAGMENTATION OF HEALTH SERVICES

Current fragmentation of health services in Israel are expressions of past developments. Health care organizations and services in Israel were fashioned by historical, political and ideological frameworks existent prior to the 1948 designation of the State of Israel. They served as alternative quasi-governmental organizations protecting and servicing their represented populations and constituencies on broad geographical bases. With the birth of the state of Israel in 1948, the organizations did not recede into the background but continued to represent the interests of their constituencies. The fundamental current health care problem faced by Israel is the integration of these multi-faceted organizations into comprehensive community care rather than competing factions. A resolution of this problem is made difficult by the pluralistic cultural and political nature of Israeli populations and the vested political interests of the care-giving services. Yet, the fragmentation does have functional results. It allows different populations to have protective institutional umbrellas in a politically divided state. But, it does make it difficult to integrate services and provide them on a regional rather than factional basis. Also, it is difficult to provide differentiated community services on the basis of epidemiologically based studies of different population needs and perceptions.

The fragmented system reflects a basic bias against social planning. This basic pragmatic bias and anti-planning philosophy results from Israels historical experience and has shapped Israeli thinking. It is a core view which helps explain why the fragmentation of institutions developed, why it has been allowed to remain, and the psychological underpinning making it possible to retain this view. In a sense, it is similar to the pragmatic philosophy accentuated as the American response to the unknown Western frontier. Teicher explains some of the root causes for this approach in Israel. (Teicher, 1976, 377)

> When the State was founded, there was a distinctly negative, even hostile, attitude toward planning. This attitude persists in many quarters today; in others, it has yielded to a stance of reserved skepticism.
>
> In earlier times, there was considerable pride in the fact that Israel was a nation of quick decision and instant action. There was a highly pragmatic orientation to the immediate present. This was tested and reinforced by repeated success in rapidly solving problems through improvisation and intuition. The prevailing point of view was that action precedes analysis; action does not proceed from analysis. Officials who made decisions promptly and who took action decisively were affectionately and respectfully known as bitzuistim, men of action. Their decisions were usually hasty, often haphazard and essentially nonrational. They were supported by the country's strong ideological orientation which gave rise to considerable hesitation and doubt about the value of a scientific approach to human and social problems. Beliefs and commitments were seen as sufficient determinants of behavior; hard evidence was neither sought nor valued.
>
> At that earlier time, it was considered wasteful to plan and to analyze. It was a time to do, to build, to move, to act. Many Israelis now look back with fond nostalgia to that period. They acknowledge the possibility that mistakes may have been made for lack of planning. But they hold that "we got results, we produced, acted, and that's what counts."

Those who maintain this attitude believe that planning postpones action. They satirize the present scene as follows: "We plan, we analyze, we study, we think, we examine, we take years to design a toilet, let alone to do something important. We have experts who debate and discuss; they are like Nero who fiddled while Rome burned. We need bitzuistim!

The negative predisposition to planning is furthered by the feeling that emphasis must be placed on the present. The future is too uncertain and too fraught with possible developments over which Israelis can exercise no control, such as Arab attacks, American support and the volume of immigration. Concomitantly, there are those who hold that it is inappropriate to be concerned with social planning and social problems; all energies must go into coping with the far more important priorities of security and the economy.

Finally, those who are opposed to planning and who deride it, point to Jewish tradition as support for their negative attitude. In Judaism, value attaches to taking action here and now in this world rather than in some ill-defined world to come. Moral acts rather than theological speculation were the traditional preoccupation of Judaism. Jews believe that the deed is more important than the creed.

5.4 ADDITIONAL PROBLEMS

Fragmentation and overlap of services for Israel's many populations are supplemented by additional problems faced by the Israeli health care system.

Cost and Budgetary Factors

There are competing needs of health care delivery in Israel. These revolve around issues such as "... preventive care versus curative care, the strengthening of community medicine versus the development of hospitals, the expansion of environmental controls versus introduction of sophisticated instrumentation, supporting nursing homes for the elderly versus a network of home care and, last but not least, health education versus provision of health services." (Modan, 1984, 228)

Health services have had to compete with other important national priorities in Israel. In its 38 years of existence, Israel has faced survival and political difficulties requiring a strong defense budget. In addition extensive migration and absorption of European and Arab-land Jews has put added strains on the budget and health care services. To the priorities of defense and absorption needs there is the additional value system of a very health conscious population utilizing services at high rates. Their attitude and value system ranks medical care high in the value scale. An attitude prevails that there is nothing too expensive for good health "... in discussion on financial and budgetary aspects of medical care, it is often felt that there should be absolute priority for all requests that come from physicians... because there are intended to save lives." (Halevi, 1979, 44) In 1960-61 Israel headed a list of 20 nations in the percent of GNP expended on health. This total expenditure increased in absolute dollars in the 1970's but the distribution of expending agencies changed. Local authority share declined in expenditures from 5% in 1966/67 to 3% in 1974-75, while the central government share increased from 31 to 44%. The total Health as part of the budget expenditure of all government authorities increased from 3% in 1969/70 to 4.4% of the total budget in 1974/75 (Halevi, 1979 , 50)

Israeli medicine lacks the high cost inflation characteristic of American health care because of the comprehensive, trade union operated medical care system. It has some common problems associated with high-technology Hadassah style medicine, e.g."Doctors unwilling to serve in rural areas or kibbutzim (and) use of immigrant doctors with lesser training as "mercenaries" to carry out the dirty work the better trained Israeli doctors refuse to do." (Silver, 55) Also despite the world's highest ratio of physicians to population (1:500 persons in 1978), Israel has an insufficient number of physicians who serve as family doctors.

In addition to a well organized system of preventive service staffed by well trained and motivated public health nurses, the Israeli health care system has characteristics of high-tech medicine. It has a hospital system in which 60% of the general hospitals are affiliated with a university teaching program, with sub specialization for high-tech e.g. 22% of hospitals have neurological facilities; 28% offer plastic surgery; and 16% have coronary and heart surgery, (Ellencweig, 1983, 375)

In contrast, the ten new development towns with Jewish immigrants from Arab countries have high welfare dependency low average annual income and a lower doctor patient ratio of 1:1,560. Also, the ratio for nurses is higher in immigrant areas than in settled cities because of the Kupat Holim attempt to achieve a better balance. (Ellencweig, 1983, 376) Most doctors graduated in Israel are absorbed into the hospitals, but few choose rural care, preventive medicine community care or general practice, slots filled by immigrant physicians.

Haim Doron of Kupat Holim noted the special characteristics of Israel's Health care needs because of its pluralistic population. (Doron, 1982, 359)

> Although Israel is a small country geographically, it has a very heterogeneous population. There are urban and rural segments with different health behaviors and different expectations of the health services system, and the several socioeconomic and ethnic segments have different utilization patterns. The more affluent urban families often seek a second opinion from a specialist, at their own expense, and have a preference for hospital-based care. The middle-level, salaried urban families demand specialist care within the public system; the lower-level, salaried urban population, like most of the rural population, generally rely on their family doctor to generate services other than primary care within the public framework. For this last group, hospital care may even be threatening.

Serious questions can be raised regarding the public welfare appropriateness of this high-tech medicine. (Modan, 1984, 228)

> On January 1, 1965, there were 12 patients with end-stage kidney disease in Israel who would have qualified for demodialysis. On January 1, 1983, there were more than 900. No major epidemic led to this dramatic increase; it stemed from the availability of treatment, and the decision that every patient deserving this treatment will get it. Similarly, there were 750 open heart operations in 1977 and close to 2,000 in 1982. Again, the increase occurred due to a change in policy. Were these the right decisions? Are we right to spend 10 percent of the nation's hospital budget on care for terminally ill cancer patients or $600,000 on a joint replacement for a single hemophiliac child, as happened recently?
>
> All public health officials strive to give the optimal treatment to everybody, but it is usually the other patient who pays for it. While the facilities for renal, heart, and cancer patients were increased in Israel, the list of elderly patients waiting for nursing care has also increased. At the same time, the range of infant mortality between affluent and less affluent districts in Israel continued to be 3 to 1, and the mortality among premature babies increased because not enough money was provided for additional neonatal pediatric units.

There is overdevelopment of highly specialized units in Health Care Services. (Doron, 1982, 361)

> Emphasis has been placed on division by specialty rather than by functional unit, and to some extent at the expense of the patient's well-being. There are many units for intensive coronary care, dialysis and intensive respiratory care... (and) a new range of special units, including those for intensive neonatal care, burns, oncology and open heart surgery. Advances in technology have added costly and sophisticated medical equipment, such as computerized axial tomography scanners, to this list. Nations that have adopted health care resources planning laws, or even principles, have

> stipulated that such units need not be part and parcel of every creditable hospital. Not only for the sake of economy, but also to ensure the necessary competence that can only be gained by continuous experience.

In addition to the above problems, there is an uneven geographical distribution of health services in Israel. (Ellencweig, 375) General bed rates in Jerusalem are 4.51 beds per 1,000 in contrast with general bed rates of 2.51 per 1,000 in the North and 2.24 beds per 1,000 in the South. In addition, the large cities with high European stock have better health care facilities and a high ratio of primary care doctors.

PART VI - STRUCTURAL REDESIGNS TO MEET THE HEALTH NEEDS OF ISRAELS POPULATIONS

There are two major approaches that have developed in Israel to cope with the fragmentation of structure and the need to deliver services more effectively to populations; regionalization and Community Oriented Primary Health Care. (C-OPHC)

6.1 REGIONALIZATION

There is movement towards regionalization of health care services in Israel. This would be a form of resource allocation or service delivery rooted in geography and result in reordering of health services within the area. It would include, "... the decentralization of power outward from a national center and the coalescene of neigborhood communities, institutions, and programs centralizing the flow of power and functions inward from the periphery. (It would) bring together, ... both the providers and the consumers of health care in an organized spatial framework that is much larger than the immediate community in which an individual lives." (Lee, 1982, 306)

The special health needs of different population groups in Israel would be advanced by the regionalization approach being advocated. As noted, (Abramson, 1982, 411)

> One of the main arguments in favor of regionalizing health care is that this will permit the development of differentiated regional health programs geared to local health problems and health hazards, local circumstances, and the interests of the local population. In fact, it may be expected that the population units for many such programs will be smaller than a total region. The needs and concerns of local communities in a region vary, as do the interests, motivations and resources of primary health care personnel working in different neigborhoods, and diverse programs can and probably should and will be operated in different communities or different population groups within a region.

Geographical and spatial integration of health services for special populations would help overcome the current fragmentation of services. Benefiting would be areas such as the Western Galilee, where, "Primary care and specialist clinics in the area are supplied chiefly by Kupat Holim, whereas psychiatric services, geriatrics, preventive medicine and public health services are in the main provided by the Ministry of Health. Thus, this area seems to be ideal for the creation of a health service region, and for a rational integration of the various services and agencies." (Ullman, 1982, 415)

In fact, a model for regionalization at Ben Gurion University in the Negev desert not only integrates services geographically, but establishes a major health sciences center as coordinator and partner in the operation. This differs from other models in Israel which use the hospital or community based systems of health care as the major coordinating and integrating regional agency. (Lee, 1982, 386)

Regional social and health programs already have been undertaken by the government in an attempt to achieve integration and heal the divisions in society. (Tulchinsky, 1982, 353)

> In 1978, the Israeli Government established as a national priority a program called Project Renewal for the rehabilitation of slum neighborhoods. Initially 69, but later 120 high-priority neighborhoods were selected for renewal. The project stresses local community planning and initiative to develop both physical and social programs for urban renewal. The social programs have tended to concentrate on the problems of the elderly, disadvantaged youth, and preschool children. The physical projects include community centers, sports facilities, day care centers, dental clinics, and expansion or renovation of crowded apartments to improve living conditions. They incorporate modern, imaginatively structured preventive health, special education and social service programs designed to have impact on the isolation and despondency of socially disadvantaged groups. This complex project involves the neighborhood community, local authorities, government ministries, donor communities abroad and the Jewish Agency. It has, in its early stages, already had considerable success in raising morale and standards of community life in the 69 communities involved to date.
>
> Project Renewal is a multiyear project based on innovative approaches to difficult social problems that have important effects on health. As such, this is an interesting community health project; the evaluation of its effectiveness can only be done through monitoring the progress of these communities over the years ahead.

The values of regionalization for meeting more effectively the health needs of different population groups is clear. However, the political obstacles and problems faced to mesh the different interest groups may be difficult to overcome.

There are political trade-offs and political costs in any regionalization of health care services. (Fein, 1982, 334)

> ... in a health system that is a mixture of private and public sectors and that is characterized by diversity among providers and financing mechanisms, regionalization is difficult to achieve on the basis of a simple technical consensus acceptable to all. ... we are dealing with political issues involving the profession, the insurance and delivery sectors, the consumer, and the government. The regional plan cannot be developed and implemented in a back room. The differences of opinion are too great and the stakes too high. It may well be that while the long-run benefits of regionalization are great the short-run costs to politicians are high.

The issue of regionalization poses problems of cost, access, manpower training and comprehensive services for the various interest groups in Israel. (Lee, 1982 , 386)

> Intervention into a social system as important as health care inevitably challenges the existing distribution of power. The diffusive power structure of a health care system like that of the United States or Israel creates problems that are difficult to reconcile with the rhetoric of equity. Regionalization of health manpower becomes enmeshed in the broader competition among interests for control over health planning decisions and health care resources.

Implementation of regionalization would pose challenges to the continued power of the dominant Kupat Holim(Klalit)health insurance plan, and would result in integrated authority not exclusively under Kupat Holim control. Facing this challenge for Kupat Holim is

Haim Doron, Chairman of the Executive Committee of Kopat Holim. He claims that Kupat Holim already has achieved the advantages of regionalization thru the Kupat Holim network, and that meshing Kupat Holim with other agencies in a region would produce significant disadvantages for health care services. His rationalizations and justifications for retaining the fragmented systems, lay bare the potential political threat regionalization holds for Kupat Holim. (Doron, 1982, 362-63)

> An honest appraisal of the major issues in regionalization, as we have now analyzed them, will show that a very significant degree of regionalization has already been achieved within the Kupat Holim system. This can be clearly demonstrated if we look at what has been done within the context of the three major frameworks referred to at the beginning of this paper: economic planning, health manpower and the organization of health care...
>
> In conclusion, there is certainly no reason to believe that improvements in the organization of health care and the application of regionalization must involve a radical reorganization of existing services. It is clear that such a radical change would be damaging to the assets already developed through existing social security mechanisms...
>
> Not every health care plan based on a regional organizational structure is necessarily a contribution to the implementation of overall objectives of regionalization. In fact, the contrary may be true, particularly if the plan threatens to destroy the basic social security tools that have contributed so much to some existing health care delivery systems. In our opinion, proposals for changing Israel's health care system pose a dangerous threat to the positive achievements in effective regionalization that already exist.

Related to this administrative proposal for regionalization is the call for a National Center of Public Health center. Ellencweig, former advisor to the Israel Minister of Health, suggested this development of an overarching institution. In essence implementation of his suggestions would override current Kupat Holim power by establishing a new agency to balance out different current political interests. He notes obstacles in Israel to a national public health approach and decries, (Ellencweig, 1982, 251)

> ... the lack of a national forum where public health issues can be debated by representatives of the major health and medical institutions. The forum should encompass the classic triad of health care providers, leaders of the health regulatory and supervisory agencies, and representatives of the academic institutions where health education and research take place.

He points out that, "... the Israeli health system has yet to adopt a common strategy for the long-term planning and training of members of the medical professions. ... the system is split by conflicting interests that reflect the duplication and the discontinuity of health services organized under many agencies."(Ellenczweig, 1982, 251)

He targets a model which would involve the major interest groups and an academic research dimension. (Ellenczweig, 1982, 252)

> ... it should be kept in mind that the health system in this nation is presently dominated by two giants - the Ministry of Health and Kupat Holim. It seems clear, therefore, that the Israeli model of a central institution should involve the major players not only as shareholders... but also as collaborators in extramural research and in the evaluative procedures. The model implies a deep involvement of the academic community, the country's natural reservoir of research talent.

The concept of regionalization discussed is an administrative model for rationalizing services. It provides for health care on a spatial and geographic basis and seeks to integrate services within the political or geographic jurisdiction.

6.2 COMMUNITY HEALTH APPROACH

The second approach in Israel for dealing with the fragmentation and need to deliver services more effectively to populations is the community health approach, developing under two community targeted programs; The concept of Comprehensive Primary Care at the Neighborhood Level and the more marketable team C-OPH (Community Oriented Primary Health Care. Both focus on designing health services for individuals based on community needs.

As one example of the community health approach, the Emec Jezreal Central Hospital has been involved in providing community services to the local area. It provides extended and home-care units, hospital consultants' services in the District Health Centres and clinics, hospital department and health centre integration schemes, and improved medical care of the population. This idea of hospital participation in primary care has been stimulated by the Committee on Organization of the Health Services which emphasizes hospitals' responsibility to support, supervise, and promote health care in the community. (Zilberg, 1983, 163)

Another example of a community health approach, Community Oriented Primary Health Care (C-OPHC) was applied by Drs. Sidney and Emily Kark on behalf of the Department of Social Medicine at Hadassah Hospital Jerusalem.

They applied this approach to, "Rural and urban communities, which differed markedly in their social structure, economy, culture and ethnicity." (Kark, 1983, 707) The health personnel were students and colleagues, from diverse national and cultural origins, ranging from highly qualified professional graduates to basic health workers selected from other communities served by the C-OPHC practices.

The Karks suggest the potential for wider applications of community medicine. They note, (Kark, 1983, 707)

> (there) is a strong case for reexamining the traditional practice of primary care (PC) in developed countries as well as in those less developed. Until very recently, primary medical care has been almost exclusively clinical, focused on the patient seeking care. With the development of teaching units in PC, such as those in general practice and family medicine, there has been a refreshing reexamination of the potential of PC beyond that of the well-established procedures of hospital medicine.

Trends toward C-OPHC in Israel include widening the scope of maternal-child clinics to include other groups, community programs focusing on prevention and control of risk factors for cardiovascular diseases, staff training for community medicine, and development of analytical tools suitable for a community based medicine information system.

A basic feature of the C-OPHC is defining the population in terms of the community as a whole, using epidemiological data to define needed community health data, use of clinical and epidemiological data as complementary resources, accessibility, community involvement in promotion of its health, and coordination of activities and services by different agencies. (Kark, 1983, 710-12)

C-OPHC if adopted on a broader scale, would require more useful profiles of the different population needs and groups in Israel. Abramson has suggested a tentative structuring of indicators which would in effect dramatically profile population health and morbidity, and alert service providers to special services required by different populations. In actual fact, use of these indicators could probably advance and solidify the operation of regionalism as a central administrative tool for delivery of community based health care. (Abramson, 1982, 412-13)

(Abramsons analytical model for targeting community based medicine)

Data on all these indicators should be obtained according to sex, age, and other variables, when this is practicable. Where appropriate, standardized rates or ratios should be computed to facilitate comparisons. In some instances, e.g., for infant mortality, it may be desirable to obtain separate data for different neighborhoods within the region.

Tentative List of Indicators

1) Demographic characteristics and social indicators.
2) Mortality, including perinatal and infant mortality.
3) Diseases:
   a) Causes of death.
   b) Diagnostic statistics of hospitalized patients, including patients in mental hospitals.
   c) Incidence of myocardial infarction and stroke. (This would require the development of special registers.)
   d) Incidence of malignant neoplasms.
   e) Incidence of road and work accidents.
   f) Prevalence of chronic diseases revealed in examinations of army inductees.
   g) Continuous surveillance of incidence of selected diseases: Notifiable communicable diseases; congenital anomalies detected at or soon after birth; acute respiratory and diarrheal diseases. This might be based on data provided by a panel of selected primary care facilities within each region.
4) Disability and impairments:
   a) Work and school absenteeism; this might be based on data collected from a panel of selected schools and work establishments within each region.
   b) Blindness.
   c) Impairments revealed by examinations of army inductees.
   d) Activity limitation and mobility limitation; this would require the inclusion of specific questions in the Labor Force or Use of Health Services surveys conducted by the Central Bureau of Statistics.
5) Somatic characteristics.
   a) Birth weight.
   b) Weight and length in infancy.
   c) Weight and height of school children.
   d) Weight, height, blood pressure, and biochemical, immunological and other characteristics of army inductees.
6) Subjective well-being; this would require the inclusion of standard questions in the Labor Force or Use of Health Services surveys of the Central Bureau of Statistics.
7) Health-related behavior.
   a) Infant feeding practices.
   b) Smoking habits; this would require the inclusion of specific questions in the Labor Force or Use of Health Services surveys.
   c) Satisfaction with health services; this would necessitate a special survey, or an addition to the Use of Health Services survey of the Central Bureau of Statistics.

Optimism regarding C-OPHC may be premature. Political problems with the interest group players in the health game may derail C-OPHC just as it has blocked regionalization. After all, C-OPHC would require a reordering of health priorities and consequently a change in delivery services and power of the major health providers.

Comprehensive Primary Care at the neighborhood level has been used to deal with the different needs of different populations in the Negev and to overcome the fragmentation of regular health care. The Negev Project for Primary Health Care was a demonstration project, designed to integrate within neighborhood clinics in several Israeli communities various health and social welfare services that were previously provided separately. The experiment established a medical school at Ben Gurion University in Beersheva in 1972 to end the fragmentation of medical services in the Negev region of Israel.

Referring to the conflicts of different interest groups, Lazin notes, (Lazin, 1983, 464)

> Officially, Kupat Holim, the Ministry of Health, and Ben Gurion University joined together in setting up the University Center for Health Services (UCHS) to develop, under a single authority, an integrated program for the delivery of preventive, curative, and rehabilitative care for the entire population of the Negev region. The Dean of the Medical School became head of the UCHS, with "formal" authority over all Kupat Holim and Ministry of Health personnel, facilities, and services in the Negev. In practice, however, the constituent organizations remained independent and in control of their own budgets, administration, programs, and personnel.

CONCLUSION

It is clear that changes are in progress in Israel's health care services. The pluralistic society with multi-population groups, interest groups, and diverse health care needs, requires a delivery system more finely turned to population based medicine. The current structure is fragmented and unable to deal in an optimum fashion with low cost, universally accessible, high quality care.

A number of environmental factors influence the direction and policy-decisions in health care, and the ability of the system to respond in an optimum fashion. Some of these are: Fiscal and budgetary constraints; Health care definitions, perceptions and biases of different population groups; Trends in global health services to move from clinical approaches to greater emphasis on population medicine; The use of the health arena as a battleground for factional political interests; Health care provision for all in an equitable manner within a beleagurd state. The need to make adjustments and accommodations in the context of a life-threatening political situation, and Ideological perception on the balance needed between a controlled central system and a community based system.

Based on the data, Israel ranks very high in terms of health care provided for all population groups. Its ability to respond effectively and creatively to current political challenges will set the stage for its continued success in dealing with the health of its many populations.

APPENDIX -A

The author of this paper has in many instances quoted extensively from primary sources. The decision to quote rather than paraphrase was made to provide information directly from the players and decision-makers rather than secondary information from observers. Many of the direct quotations are from actual participants in the shaping of events involved in decisions related to the events they are analyzing.

For the above reasons, I have described the roles and positions of a number of key authors at the time their material is quoted.

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